Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34501 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Connie Nall 9:49p M Medical Novembei 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Baltimore Towson Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign Mav 23,1960 218-80-2148 1 M 2 XF Months Director 50 Maryland Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Md. Baltimore Dundalk 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6917 Broening Road 21222 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business Industry during most of working Elementary/Seconday (0-12) College (1-4 or 5+) 12 years Payroll & Billing Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 John Calvin Nall Vera S. Herring 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melvin Nall Brother 3437 Dunran Road, Dundalk, Md. 21222 NOVEMBER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State November 4 Donation 5, Other (Specify) Sacred Heart Of Jesus' Dundalk, Maryland 6, 2010 21 22. Name and Address of Facility Connelly Funeral 7110 Sollers Poi Funeral Home Of Dundalk, ers Point Road, Dundalk, 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death **MELANOMA** disease or condition edical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or ilinjury that initiated events Physician/Medical Examiner Due to (or as a consequence of): attending physician and for use as the burial-transi Due to (or as a consequence of): resulting in death) Last The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy ate has been signed by the atte page 2 should be detached for Pregnant at time of death 5 Other (specify) Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 X No After this certificate 1 Yes To the Hospital or Attending Physician: eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical BB 26. Place of Death (Check only one) Hospital မ 1 Yes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 👿 Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pendina 2 Accident
3 Suicide
4 Homicide 1 Yes Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 24 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29d. Date signed (Month, Pay, Year)

State Registrar

DHMH 17 Rev 7/2009

30. Name and add

JACKIE

JONES,

CRNP

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month October 31, 2010 Franklin Clinton Ness 11:30 P. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3540 Keswick Road Baltimore N/A 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 😿 M 2 🗆 F Months Davs Hours (Month Day Y Country) Maryland 218-28-6281 Director September Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Director r 28a-f sh notified N/A XXX Yes 2 No Maryland 1 4 1 Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a o Funeral 3540 Keswick Road 21211 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces Black White etc. ²Korea ģ 1 Never Married 2 X Married X Yes Baltimore, Maryland 21215-0036 1 Yes 2XX No Specify: If Yes, Give Year or Dates White Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Painter Painting Company is marked other aumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elmer Franklin Mary Margaret Dennis 27 is marked r traumatic e 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian Ann Ness Wife 3540 Keswick Road, Baltimore, Maryland 21211 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 1 🔀 Burial 2 📮 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 Donation Other (Specify) Crest Lawn Memorial 11/5/2010 Marriottsville, Maryland 22.Name and Address of Eacility Burgee Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 21. Signature 21211 23a. Part 1. Exper the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ reward disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Corons diserse worth Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of, Cause (Disease or iinjury that initiated events resulting in death) Last the bunial-tran Due to (or as a consequence of): attending physician of for use as the burial-Hospital or Attending Physician: The law requires that the death certificate be ex Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 2 No 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral (28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 1 Aatural 5 Pending 1 🗌 Yes 2 🗌 No after death Director: the f Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier peteldn Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2
To the F 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Sale 052113 Nov 5 mis 30. Name and address of person who comp ed cause of death (Item 23a) (Type, Print) CLUN OUVES Be Himme 21200 st ran

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

4 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October Physician/ 2010 24 7:36 РМ Joseph Thomas Nason Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Hospice Towson Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days July 25, 1938 1 🖾 M 2 🗆 F Months Hours Min. Maryland 213-34-7976 72 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 ¥ Yes 2 □ No Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code Funeral 21206 USA 3901 Frankford Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 white Yes Give 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 0 lumber salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Anna Elizabeth Jory Charles Peter Nason 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 3901 Frankford Ave; Baltimore, Maryland 21206 Mary Nason - wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityState Anatomy Board Signatur of Funeral Sinvice License 655 W. Baltimore Street; Baltimore, MD 21206 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Ons the or heart failure. List only one cause on each line. Immediate Cause (Final Ph, sician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No Yes the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospita Other: ၉ 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending within 24 hours after death. To the Funeral Director; At 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

State Registrar

29b. Signatu

and address of person who completed cause of death (Item 23a) (Type, Print)

Year 4

Registrar's Signature

License number

29d. Date signed (Month, Day, Year)

Benjamin Thom	nas I	Parker Sta 1- For State Registrar	e or Print in B ite of Maryland	/ Depa		f Health	h and M		/giene	2 (Reg. No.	010	3450
Physic Medical Exam		Decedent's Name (First, Middle		т					2. Date of De Month October :		ear	3. Time of Death 1642 hrs
A LAGINA		Benjamin Tho 4a. Facility Name (if not institution				4b. City, To	own, or Local	tion of Death	October	31, 2010 4c. County	of Death	
		2184 Jaceb Tome High	iway			Port D	eposit			Cecil		
Funeral Director		222-26-2884	5. Sex 7. A(1	ge (In yrs. I	last birthday)	If Under Months		Under 24Hrs. lours Min.	7	irth (MM/DD/YYY 2, 194.2	Co	hplace (State or Foreig untry) Laware
any		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Locat	ion		-				10d. Inside City Limits
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death with the Maryland or items 23a or 28a-f sho must be notified at once.	Director	10e. Street and Number				10f. Zip C				10g. Citizen of W	/hat Cour	itry?
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ath wi	Funeral	11. Marital Status 1 Never Married 2 Mar	ried Armed Forces	Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Whit						e - Amerio te, etc.	can Indian, Black,	
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d with ygiene ther t	Com	12 17. Father's Name (First, Middle, L	ast)		Mac	ninist		ther's Name	First, Middle.	Maiden Surname	F.M.(J
2121 uld be fil Mental I marked	Be (Benjamin Parker	Sr.					Marv	Elizab	eth Adar	ns	
	2	19a. Informant's Name/Relationshi	p (Type, Print)					Number or R	ural Route Nu	mber, City or Tov	wn, State,	
, MD and 2 sho ealth and cent 27 is		Wayne M. Parker, Son 211 Ryan Drive Rising Sun, Maryland 219 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City of										
10re ages l nt of H t: If ii		1 Burial 2 Cremation 3 Removal from State crematory or other place)										
Baltimore, permit. Pages I an Oppartment of Hee Important: If ite Injury or other in		4 Donation 5 Other Specify: Metro Crematory Inc. 11/01/10 Baltimore 21. Signature of Funeral Service Licensee Thomas Gregor 22. Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryl										Maryland
Berr Depri		Jumau X	w		1 29	emati 99 Fre	ion So ederic	ciety k Roac	Of Mar LBalti	yland, i	Inc. arvla	and 21228
Physician		23a. Part I. Enter the disease, or co failure. List only one cause of	emplications that caused n each line.	the death	. Do not enter th	e mode of	dying, such a	as cardiac or	respiratory an	rest, shock, or he	eart	Approximate Interval Between Onset and
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tal Records, P.O. Box 68760, cian: The law requires that the death certificate be execut certificate has been signed by the attending physician and ector, page 2 should be detached for use as the burial - tran	an/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	me of pregi	,	al death	3 Ect	opic pregnan	су	23d. Date of Month	f delivery Da	ay Year
OX 6 ath cer attendi	sicie	1 Yes 2 No 9 Unkno	4 Pregnant at	time of de	ath 5 Oth	er (Specify	/)					
D. B. the de by the	Physici	Part II. Other significant condition	9 Oliknown	h but not re	esulting in the u	nderlying ca	ause given ir	Part I.	23e. Did t	obacco use contr	ribute to t	ne cause of death?
P.C es that igned be deta	آھ					, , ,	g		1 Ye	s 2 No 3	Proba	ably 4 Unknown
rds, requir	Completed								24a. Was			opsy findings available
eco he law te has age 2 s	d mc									rmed?	death?	empletion of cause of
Vital Rec ysician: The his certificate director, page	BeC	25. Was case referred to medical				26.	Place of De	ath (Check or		2 🖳 110	100	2 140
Division of Vital Records, P.O. fall or Attending Physician: The law requires that the rs after death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	To B	examiner? 1 ✓ Yes 2 No			ER/Outpatient			- Harsing	Home 5	Residence 6	✔ Other:	Scene
n of \ding Phy. h. After the funeral	ä	27. Manner of Death 1 ✓ Natural 5 Pendin	28a. Date of Inju (Month, Day,Y	iry 'ear)	28b. Time of Ir	jury 28c	. Injury at W		8d. Describe	how injury occurr	red	
IVISIOF or Attend after death Director:	Cati	2 Accident Investig	gation 28e Place of In	ilury - At ho	me farm stree	factory of	Yes 2		Of Location (Street and Numb	er or D	al Poute Number Chi
Divirial or	Certification:	3 Suicide 6 Could r 4 Homicide	lot be	y⊶ry = ALTIC	o, iaiiii, siiee	, iactory, or	ce building	, 610.	or Town, S		ei or Kura	al Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri		29a. Certifier 1 Certifying Phys	sician: To the best of m	y knowledg	ge, death occurr	ed at the tin	ne, date and	place, and d	ue to the caus	se(s) and manner	r as stated	i.
To the within To the comple	Medical	one) 2 Medical Exami	ner: On the basis of examend manner stated.	mination ar	nd/or investigati	on, in my op	oinion, death	occurred at	the time, date	and place, and d	due to the	cause(s)
	- 5	29b. Signature and title of certifier				29c. L	icense numb	per		29d. Date sign	ed (Mont	h Day Year)

Yes 2 No 9 Unkno	Wn 9 Unknown				
rt II. Other significant condition	s contributing to death but not	resulting in the underlying cau	ise given in Part I.	23e. Did tobacco i	use contribute to the cause of death?
				1 Yes 2	No 3 Probably 4 ✔ Unknown
				24a, Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Was case referred to medical		26.P	lace of Death (Check	only one)	
examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 DOA	Other Nursi	ng Home 5 Reside	nce 6 Other: Scene
. Manner of Death Matural 5 Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c.	Injury at Work?	28d. Describe how inju	ry occurred

27. Manner of Death	28a. Date of Injury	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 Natural 5 Pending	(Month, Day, Year)		1 Yes 2 No	
2 Accident Investigation			C. C. S. L. C.	And the second of the second of the second of
3 Suicide 6 Could not be	28e. Place of Injury - At h	ome, farm, street, factor	y, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)
4 Homicide determined	(Specify)			or Town, State)
29a. Certifier 1 Certifying Physician	: To the best of my knowled	ge, death occurred at th	e time, date and place,	and due to the cause(s) and manner as stated.
one) Medical Examiner: 0	n the basis of examination a	ind/or investigation, in n	v opinion, death occurre	ed at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 1, 2010

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a)

Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State 31. Date filed (Month, Day, Year) Registrar

34504

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NSON M GOII 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges 7908 Springfield Road Glenn Dale 8. Date of Birth (Month, Day, March 17 9. Birthplace (State or Foreign Country) Kansas Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Min. M 2 🗆 F Months Hours 217-28-8474 79 **Director** Usual Residence of Decedent of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 🗌 Yes 2 😾 No Maryland Prince Georges Glenn Dale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20769 United States 7908 Springfield Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? 1948 Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes. Give 1 ☐ Yes 2 🔀 No Specify. Specify: 1957 Completed 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) NASA Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ethe1 Hanson D. Powers, Harwood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Diane C. Cohen, Daughter 4804 Royal Crossing, Bowie, Maryland 20715 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or otl 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory,Inc. 11/3/2010 Baltimore, Maryland Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of FacilitCremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burlal-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for u in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No 1 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: ၉ 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Tother (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury 5 Pending 1 🗌 Yes 2 🗌 No Investigation Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010 veriens 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) HWY ANNAPOLIS, M.D. ZIYOTI DEFENSE 001-1A460R 32. Registrar's 31. Date filed (Month Day State Registrar

DHMH 17 Rev 7/2009

State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ Dorothy K. Peters Medical 4a. Facility Name (if not institution, give street and number) **Examiner** Stella Maris Hospice Timonium Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director 89 491-14-6043 Usual Residence of Decedent or 28a-f shov 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location Director FL Palm Beach Highland Beach 10e, Street and Number 10f. Zip Code Funeral 3407 S. Ocean Blvd. Apt. 8D 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give а.п Completed by 1 Never Married 2 X Married 21215-0036 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) n/a Homemaker 2010 Be Maryland 17. Father's Name (First, Middle, Last) ပ J. Elmer Kleimeier 19a. Informant's Name/Relationship (Type, Print) Apt 8 Henry J. Peters/husband 3407 S. 0cean Baltimore, OCTOBER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State Atlantic Crematory 4 Donation 5 Other (Specify) Signature of Europe ervired includes Michael J. Flagle Immediate Cause (Final ysician/ SEPSIS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Physician/Medical Examiner Due to lor as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transi Due to (or as a consequence of) resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 **X** No Pregnant at time of death g Unknown Unknown signed by DOROTHY PETERS Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by within 24 hours after death.

To the Funeral Director: After this certificate has been ammeleted filled in by the funeral director, page 2 should Be 25. Was case referred to medical examiner? Hospital Other: ၉ 1 🗌 Yes 2 👿 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 29a. Certifier 3

2. Date of Death 2010 Year Oct. 11:10 A M 4b. City, Town, or Location of Death 4c. County of Death Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Date of Day (Month, Day 22) 9. Birthplace (State or Foreign Min Country) l'921 10d. Inside City Limits 1 🗌 Yes 2 😾 No 10g. Citizen of What Country? 33487 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or Nollf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc white Specify. 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Own Home 18. Mother's Name (First, Middle, Maiden Surname) Mayme Horstman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Highland Beach, FL 33487 20c. Location - City or Town, State Date 11/1/10 Glen Burnie, MD 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23d. Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 🗌 No 3 🗋 Probably 🚜 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 🗌 Yes 2 🗶 No 1 L Yes 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 2016 (Item 23a) (Type, Print) Name and address of person who completed cause of death ERNESTINE WRIGHT, MD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State 4 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 7/2009

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State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	ir ylaria / E	Certific				-	Reg. No.	010	34507
	Dhoriei		1. Decedent's Name (First, Middle, Las	st)					- 1	2. Date of Dea	ath Day	Year	3. Time of Death
	Physicia /Medic		Lillian Pferdeor	t					(Octobe	r 21	2010	11:25 A M
The same	Examin		4a. Facility Name (If not institution, giv				ity, Town, or		f Death			ounty of Death	1
عمرر			Brightview Assis				Bel Ai		24.11			arford	. (0)
	Funeral Director		215-12-7419	Sex 7. Age	(In yrs. last bir	Yrs. Mon	nder 1 Year ths Days	If Under 2 Hours	Min	B. Date of Bird (Month, Da Dec 19	v. Year)	1 600	nplace (State or Foreign untry) nsylvania
	pu *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location							10d. Inside City Limits
	aryla sho	ក	MD Harfo	rd	Be1								1 □Yes 2√∑No
	he M	ect	10e. Street and Number				Zip Code				10a. Citize	en of What Cou	untry?
	23a or	Funeral Director	300 Ring Factor	y Road			21014				US.	Α	
21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural" or items 23a or 28a-f show aumatic event, the Medical Examitive must be notified at	þ	11. Marital Status 1 Never Married 桑口 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2 ▼ N If Yes, Give Year or Dates:			ecedent of Hi specify Cuba s 2🏋 No	spanic Orig n, Mexican Specify:	gin? (Spec , Puerto F	cify Yes or No lican, etc.)		4. Race - Amer Black, White Specify: Wh	ite
<u>ခု</u>	72 ho natur lical	ted	15. Decedent's Ed (Specify only highest gra	ducation	16a	Decedent's	Usual Occupa	ation	t of workin	g	16b. Kind	d of Business/I	ndustry
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ڇ	d 2 should th and Mer 7 is marke traumatic	으	19a, Informant's Name/Relationship		101	Mailing Add	roos (Stroot	and Numbe	or or Puro	Route Numb	er City or	Town, State, Z	Zin Code)
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a,	1 and Health tem 27 other to		20a. Method of Disposition		20b. Place o	f Disposition	(Name of	i		ate		ation - City or	
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Special		cemete	ry, crematory	·						
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	Examiner			b									
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J.	that t ed by detac		Part II. Other significant conditions	contributing to death b	ut not resulting	in the underly	ing cause giv	en in Part I		23e. Did	tobacco us	se contribute to	the cause of death?
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Division of Vital	or Attending Physician: after death. Director: After this certifica I in by the funeral director, p	Certification:	2 Accident 3 Suicide 4 Homicide	pe Place of Init	ury - At home, f c. (Specify)	arm, street, fa				28f. Location City or To	(Street and wn, State)	d Number or R	ural Route Number,
_	To the Hospital or Al within 24 hours after of To the Funeral Direct completely filled in by	Medical Co	29a. Certifier (Check only one) Certifying P	Physician: To the best miner: On the basis of and manner st	of examination a	ge, death occi	urred at the ti ation, in my o	me, date a opinion, dea	nd place, ath occurr	and due to th ed at the time	e cause(s) , date and	and manner a place, and du	as stated. e to the cause(s)
	o the vithin o the omple	Mec	29b. Signature and title of certifier	and manner at			29c. Licens	se number		-	29d. Date	e signed (Mon	th, Day, Year)
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			30. Name and address of person who	completed cause of a	leath (Item 23a)	D32239 PCT2her 25, 2010							
			David Dunn 615					r MD	2101/	'n			
	Sta	ate	31. Date filed (Month, Day, Year)	2. Registr	ar's Signature	100	A T	للتنوي	<u></u>				
	Regist		MOV 0 4 201	1 /2	M. W	MIR AL							

Physician /Medical Examiner **Funeral** Director 28a-f show ral", or Items 23a or 28a-f shov Director Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death a nent of Health and Mental Hygiene. int: If item 27 is marked other than "natural", or Items 23 Baltimore, Maryland 21215-0036 Be ည other ь

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 22 2010 9:38 Рм Edward Kevin Pride 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 7088 Ducketts Lane; Apt 301 Howard Elkridge If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, July 2, 9. Birthplace (State or Foreign 6 Sex 7. Age (In vrs. last birthday) Days Hours Min. New York 11 M 2□ F 53 099-46-4223 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Elkridge 1 ☐ Yes 2 No MD Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21045 USA 7088 Ducketts Lane; Apt 301 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No 1976 − If Yes, Give Year or Dates: 1981 1 Never Married 22 Married 1 ☐ Yes 2 ☑ No Specify: Specify: black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Rusiness/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Express customer service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lucille McDaniel Darshford Pride 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Pride - wife PO Box 1215; Colorado Springs, CO 80901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or 4□Donation 5x Other (Specify) in state 21. Signature Comeral Service Sicensee Wade, Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street; Baltimore, MD 21201 m 231. Part1. Ehier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a. Atheroscleratic /Medical Due to (or as a consequence of): Examiner new-ofic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Physician/Medical Examine Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 ☑ No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 29a. Certifier 1. certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charle Leon 10710 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

P.O. Box 68760,

Division of Vital Records,

10-08003	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Harold Scott Pall		legistrar Reg. No.	+509
Physicia Medical Examin		1. Decedent's Name (First, Middle, Last) Harold Scott Palmer 2. Date of Death Month Day Year October 18, 2010 1628	
medical Exami	ici	Harold Scott Palmer October 18, 2010 1628 A. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
,		2832 E. Federal Street Baltimore	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1	
any.	ł	Usual Residence of Decedent 10c. City, Town or Location 10d. Inside 10a. State 10b. County 10c. City, Town or Location 10d. Inside	City Limits
*	ᅵ	MD Baltimore 1∑Yes	2 No
r death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	10e. Street and Number 2832 E. Federal Street 10f. Zip Code USA 10g. Citizen of What Country? USA	
2) To hours after death with the Maryland "natural", or items 23a or 28a-f sho al Examiner must be notified at once	Funeral	12. Was Decedent Ever in U.S. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, White, etc. 15. Widowed 16. Widowed 17. Wes 16. Widowed 17. Wes 17. Wes 18. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, White, etc. 15. Widowed 17. Wes 18. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 15. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. Race - American Indian, White, etc. 17. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 18. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 18. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 18. Was Decedent Ever in U.S. 19. White, etc. 19. Widowed	Black,
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215 be filed atal Hy rked of	Be	George M. Palmer Carol D. Schott	
O 21 should Ind Men is man	P	9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
and 2 s and 2 s ealth a tem 27	ŀ	Benjamin Palmer - brother 1411 E. Joppa Rd; Towson, Maryland 21286 Oa Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State	
TOFE ages 1 nt of H at: If ii		1 Burial 2 Cremation 3 Removal from State crematory or other place)	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.	ł	4 Donation 5 Nother Specify: in state	
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Physician / / / / / / / / / / / / / / / / / / /		failure. List only one cause on each line.	ate Interval Onset and eath
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Peco The law ate has	g	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2	No
tal Rection: The certificate	8	5. Was case referred to medical 26.Place of Death (Check only one)	
of Vir Physical Physical direction	라	1 Ves 2 No The state of the sta	
on c ending ath. or: Aft	tion	1 X Natural 5 Pending (Month, Day,Year) 1 Yes 2 No	
Division of Vital Records, P.O. Box 687, spital or Attending Physician: The law requires that the death certifications after death. Toral Director: After this certificate has been signed by the attending pittled in by the funeral director, page 2 should be detached for use as the	Certification	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or Rural Route Number or Town, State)	mber, City
8 >1	Medical C	9a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ne) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	Ĭ	9b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yea	r)
	-	O.C.M.E. October 19, 2010	
		0, Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 1. Date filed (Month, Day, Year) 32. Registrar's Signature	
Sta Registr		NOT 0 4 2010	
DHMH 17 Rev 1/20	01	ORIGINAL	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death E. Powell Physician/ Mary October P M 2010 4:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death St. Elizabeth Nursing Home Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign Sept. 28.1917 1 M 2 X Days Hours Min. Maryland Director 212-24-9352 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 748 S. Woodington Road United States death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify: White should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", Specify: 3 X Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8th N/A Waitress Food Service permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Gross Nellie Kuhn Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Shirley May Kilduff/ Daughter 319 Stafford Drive, Catonsville, Maryland 21228 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadworidge Mem.Park Nov.4,2010 Elkridge, Maryland 22. Name and Address of Facility AMBROSE FUNERAL HOME, INC. gnature of Pineral Service Licensee 1328 Sulphur Spring Rd., Arbutus, Maryland 21227 allicia 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Rmen disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner fibrillation atrial Sequentially list conditions, Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): sician and burial-trans Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 2 No 3 □ Probably 4 □ Unknown 1 Tes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, it 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? မ 2 X No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3 Joven ver 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W D 31. Date filed (Month, Day, Year) egistrar's Signatur State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

etra Pun	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No.											
Physician/	Registrar 1. Decedent's Name (First, I	Middle,Last)				2. Date of Dea	ath	3. Time of Death				
edical Examiner	Netra Pun					Month October 2	Day Year 28, 2010	1607 hrs				
	4a. Facility Name (if not inst Howard County Go	itution, give street and number) eneral		4b. City, Town Columbia		of Death	4c. County of E Howard	Death				
Funeral	5. Social Security Number	6. Sex 7. Ag	e (In yrs. last birthday			r 24Hrs. 8. Date of Bi	irth(MM/DD/YYYY)					
Director	586-23-1498	1 X M 2 F	49	Yrs. Months E	Days Hours	Min. Feb 14	, 1961	oreign Country) Nepal				
any	Usual Residence of Decede 10a. State 10b. Cou		10c. City, Town or L	ocation				10d. Inside City Limits				
. ≨	MD Bal	timore	Windsor M	i11				1 Yes 2 XXNo				
Aaryland 28a-f show 1 at once. ector	10e. Street and Number			10f. Zip Cod	е		10g. Citizen of What	Country?				
the M sa or 2 stiffed	3 Giard Dr Apt	# 8		21244			Nepal					
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. ilen 27 is marked other than "natural", or items 23a or 28a-f short reaumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2	X Married 12. Was Decedent Armed Forces?				in? (Specify Yes or No Puerto Rican, etc.)	o- 14. Race - A White, e	merican Indian, Black, tc.				
ifter d	3 Widowed 4	Divorced If Yes, Give Year	No specify:		Specify:	Asian						
iours aft tatural" xamine	15. Decedent's Education	Specify only highest grade com	pation (Give l	kind of work done	ess/Industry							
5-0036 ed within 72 hour lygiene. other than "natu ihe Medical Exan	Elementary/Secondary (0	-12) College (1-4 or 5	use retired)									
5-0036 led within 7 Hygiene. other than the Medical	1.2 17. Father's Name (First, Mi	ddle Lest)		Delive	ry Drive	e r s Name (First, Middle,	Restau	ırant				
21215-0036 suld be filed within 7 Mental Hygiene. marked other than cevent, the Medica	Jag Bahadur Pun	•	Maya Pun	manager darramay								
2121 hould be fill nd Mental F is marked rite event, I	19a. Informant's Name/Rela	tionship (Type, Print)	19b. Ma	ailing Address (St	treet and Num	ber or Rural Route Nu	mber, City or Town, S	State, Zip Code)				
e, MD 1 and 2 sho Health and item 27 is r traumati	Devkeni Pun	Wife				, Windsor Mil						
_ = 2 × 2 = 2	20a. Method of Disposition 1 Burial 2 v Crem	ation 3 Removal from Sta	ate crematory o	sposition (Name of or other place)	cemetery,	Date	20c. Location - Cit					
imore Pages 1 ment of H tant: If i	4 Donation 5 Othe	er Specify:	Local Cremator			11-11-2010	Lekhanath,	Pokhara, Nepal				
Baltimore, permit. Pages I ar Department of Hec Important: If ite injury or other tr	21. Signiful of Funeral Service Licensee 22. Name and Address of Facility Fink Funeral Home, Glen Burnie, MD 21061											
Physician	23a. Part I. Enter the diseas	e, or complications that caused	the death. Do not en					Approximate Interval				
Medical	failure. List only one ca Immediate Cause (Final disc	A 1 .						Between Onset and Death				
Examiner	or condition resulting in dea	th) Due to (or as a conse										
5	Sequentially list conditions, if any, leading to immediate	b. Chocking on foc						_				
nsit Examiner	cause. Enter Underlying Ca (Disease or injury that initiat	ause C.										
cuted md transit	events resulting in death) L	ast Due to (or as a conse	equence of):									
6 be executed ysician and burial - transit	UNPENDED	AMENDED										
ox 68760 eath certificate be attending physicar use as the busician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregnancy	E. a. l. b. a. d.	3 Ectopic	pregnancy	23d. Date of del Month					
b. Box 68760 the death certificate oy the attending phy ched for use as the Physician/Me	past 12 months?		time of death 5	Fetal death Other (Specify)	3 Ectopic	pregnancy	Monu	Day Year				
Bo, te death the att the att for thy since for the street for the	1 Yes 2 No 9	Unknown 9 Unknown										
b, P.O. Bo irres that the de a signed by the d be detached f ed by Phy	Part II. Other significant co	onditions contributing to death	but not resulting in t	he underlying caus	se given in Pa			e to the cause of death? Probably 4 Unknown				
duires en sign uld be ted						24a. Was		e autopsy findings available				
Records, The law require ficate has been si page 2 should b						autop	psy prior deat	to completion of cause of				
tal Rection: The Lectificate bector, page				00.50		1 ✓ Yes	2 No 1 🗸	Yes 2 No				
Vital ysician: his certif director,	25. Was case referred to me examiner?	Hospital:	nt 2 🗸 ER/Outpat		-04	Check only one) Nursing Home 5	Residence 6 0	lther:				
n of Vit ling Physic After this funeral dire	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Inju	ry 28b. Time		njury at Work		how injury occurred					
ion (tendin eath tor: A the fur		Pending Oct 28, 2010	0000 hrs	1	Yes 2	No Subject cho	oke					
Division of Vital Records, P.O Hospital or Attending Physician: The law requires that to 24 hours after death tely filled in by the funeral director, page 2 should be detacted filled in by the funeral director, page 2 should be detacted at Certification: To Be Completed by Is	3 Suicide 6	Could not be determined (Specify) Res	ury - At home, farm,	street, factory, offic	e building, etc	or Town, S		r Rural Route Number, City				
C Fill bo bi	(5.1.5511 5.1.1)	ng Physician: To the best of my	knowledge, death o			ce, and due to the caus	se(s) and manner as	stated.				
To the Ho within 24 To the Fu completel	one) 2 ✓ Medical 29b. Signature and title of ce	Examiner: On the basis of examiner and manner stated.	nination and/or inves		ense number	curred at the time, date	29d. Date signed					
2	29b. Signature and title of ce	auner			C.M.E.		October 29, 2					
	30. Name and address of pe	rson who completed cause of de	eath (Item 23a)				I					
		Assistant Medical Exam		n Street, Baltii	more, MD	21201						
State Registrar	31. Date filed (Month, Day,Y	(ear) 32. Registrar	s Signature	Mad								
DHMH 17 Rev 1/2001 OCMF 2006	- 6404-4	- auto pomiti	ORIGI	NAL								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 2, 2010 Physician/ 1:27 P M GERTRUDE M. ROGGIO Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore County STELLA MARIS HOSPICE Timonium If Under 1 Year | If Under 24 Hrs. . Social Security Number 9. Birthplace (State or Foreign Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🛚 F Months Hours Feb 25, Ye 95 Marryland 215-01-2809 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits with the Maryland event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 🕅 No Towson Maryland Baltimore County 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? Funeral items 23a 21286 USA 800 Southerly Road hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 X No and Mental Hygiene. is marked other than "natural", or 1 Never Married 2 Married þ 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Completed 3 X Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Own Residence Homemaker Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev onee. ည Alexander Kalinowski Sophie Woradska 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Daughter-in Riverboat Lane, West, Hartfield, VA 23701 Mary J. Roggio 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Gardens of Faith Cem 11/4/2010 4 Donation 5 Other (Specify) Rosedale, Maryland 21. Signal of Furgal Second Section 2. Lawson ²² Name and Address of Facility Funeral HOME, MITCHELL-WIEDEFELD FUNERAL HOME, 6500 York Road, Baltimore, Maryl 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ a. CEREBROVASCULAR ACCIDENT disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Completed by Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or linjury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav Year 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 1 Yes 2 2 9 Unknown this certificate has been signed by the all director, page 2 should be detached Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No fune al director, page 2 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Yes 2 🕱 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After work? injury 1 X Natural 5 Pending To the Hospital or Attendir within 24 hours are death.

To the Funeral Director: At completed filled in by the fu death. 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and tit 29d. Date signed (Month, Day, Year) 20 0

Registrar

DHMH 17 Rev 7/2009

12

State

2010

NOVEMBER

GERTRUDE ROGGIO

TTMONTIM.

MD 21093

2300 DULANEY VALLEY RD.

32. Registrar Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

JACKIE JONES,

10-08344 Mary Stewart Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Registrar 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle,Last) Physician/ Month Day November 1, 2010 0939 hrs Medical Examiner Stewart Mary <u>Agnes</u> 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** 4732 Old York Road 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Country) Months Days Hours NOV 17, 1916 Maryland Director 93 1 M 2 X F 212-46-9659 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 X Yes 2 No s 23a or 28a-f show a e notified at once. N/A Baltimore MD Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Director 10g, Citizen of What Country 10f. Zip Code 10e. Street and Number 21212 4732 Old York Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Was Decedent Ever in U.S. Funeral If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 X No Yes 1 Yes 2 X No specify: Specify. Black Divorced If Yes, Give Year ۾ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Daycare Provider Child Care 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Woodland Anna Henry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary Elizabeth Stewart, daughter 865 Bradhurst Road Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a Method of Disposition timore, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 11/02/10 Baltimore, MD permit. Pages Department of Important: I Metro Crematory, Inc. Donation 5 Other Specify þ 22. Name and Address of Facility Cremation Society of MD, 21. Signature of Funeral Service Licensee George MacNabb Baltimore, MD 299 Frederick Road 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and **Physician** failure. List only one cause on each line Death /Medical a. Neck injury Immediate Cause (Final disease ≟xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical AMENDED signed by the attending physician be detached for use as the burial UNPENDED Box 68760, 23d. Date of delive 23c. If yes, outcome of pregnancy IF FEMALE: Year Month Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify, 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 1 Yes 2 V No 3 Probably 4 Unknown \$ ٣. Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? After this certificate has ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical of Vital Be Other:4 Nursing Home 5 Residence 6 🗸 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 1 Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) NoV 1, 2010 28c. Injury at Work? funeral 28b. Time of Injury 27. Manner of Death Subject fell down the stairs 0930 hrs 1 Yes 2 ✔ No 1 Natural Division Pending death. the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City To the Hosping Within 24 hours after de To the Funeral Direc in by 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be 3 Suicide or Town, State) 4732 Old York Road, Baltimore, MD determined (Specify) Single Family Home Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 2, 2010 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Margarita Korell MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Registrar's Sign ture State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ 009 A M RE G(S)Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 1ARBO OSAITAI LTIMARE if Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Min. 1 □ M 2 👿 F Maryland 214-72-1592 Yrs. 1970 40 Director Usual Residence of Decedent 28a-f shov iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director N/A 1 🏋 Yes 2 🗆 No Brooklyn MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 3716 9th Street 21225 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married ☐ Yes 2X No Maryland 21215-0036 han "natural", e Medical Exan If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White Completed 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry e filed within all Hygiene. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Hazardous Materials and Mental Hygier is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Unk. Stidham Sharon Unk. permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3716 9th Street Brooklyn, MD 21225 Steven D. Freeman, son altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 11/02/10 Baltimore, MD 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, 299 Frederick Road Baltimore. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Disable for this a monsequence of cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events physician and sthe burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 □ Xes 2 □ No Month Day Year the detached 9 Unknown P.0. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 pe Division of Vital Records, 2 No 3 Probably 4 Unknown Completed page 2 should been (24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performe within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 No 1 Yes or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 2 N6 1 Tes 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 451 CTQ 30. Name and address of person who completed cause of peath (Item 23a) (Type, Print) has 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 20ÎÖ 9:00a M C. Sullivan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3810 Littleton Street Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)Spain 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Dec. 12 1 M 2 X F Days Min. 1925 84 220-82-4694 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 28a-f 1 Yes 2 X No Silver Spring Marvland Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ò Funeral 23a 20906 3810 Littleton Street United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ŏ Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White "natural" 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Own Be permit. Page 1 and 2 should be file.
Department of Health and Mental H.
Important: If item 27 is marked any injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mario Molinari Tani Electra 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3810 Littleton Street, Silver Spring, MD 20906 James F. Sullivan, Husband 20a. Method of Disposition
1 □ Burial 2 🗗 Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 11/4/2010 Baltimore, Maryland 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of FacilitCremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Kel disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this continued in the Funeral Director: Box 68760 IF FEMALE: yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 🛂 No Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 🗌 Yes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes Hospital Other: 2 No ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 XNatural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) OTTOG 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greenway Center De #1100 Greenbeltomo C-Sahni DR-Rakesh 31. Date filed (Month, Day, Year) 32. Registrar's Signature, State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2010 4:00 PM Marguerite Carmen Suarez-Murias November Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Holly Hill Nursing Home Baltimore Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours Min March 23 267-30-4092 Cuba 89 Director Usual Residence of Decedent 10c. City, Town or Location 28a-f shov 10b. County 10a. State 10d Inside City Limits Examiner must be notified at death with the Maryland Director Maryland Baltimore Baltimore 1 ☐ Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Funeral items 23a 21212 531 Stevenson Lane United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 X No Black White etc. 1 X Never Married 2 Married "natural", or þ Baltimore, Maryland 21215-0036 1 XX Yes 2 □ No Specify: If Yes, Give Year or Dates Cuban white Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical sonce. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ professor education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eduardo Ramon Suarez-Murias Marguerite Vendel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 118 Willow Ave. Towson, MD 21286 Lawrence Suarez-Murias/nephew 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Druid Ridge Cemetery 11/11/2010 ☐ Donation 5 ☐ Other (Specify) Pikesville, Maryland 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Rd. Baltimore, MD 21212 ignature of Eunera Part 1. Enter the disease, or co shock, or heart failure. List or plicitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ artery cronary disease or condition Medical Examiner resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter on derlying Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After t 1 Natural 5 Pending I Director: A 1 🗌 Yes 2 🗌 No hours after death. 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completed filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier

State Registrar (Check

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) NOV 0 4 2010

Jula

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

40

32. Registrar's Signatu

ork

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

RJ#301

29d. Date signed (Month, Day, Year)

owsen MD 21204

			Flease	State of Maryla				•		ibie.			
			1 - For State Registrar	State of Maryla	•	tificate of D			20	10	31.517		
			Decedent's Name (First, Middle, Last))		timodito or D		2. Date of Death	g. No	10	3. Time of Death		
	Physicia Medic		Edward Micha	el Simon,	Jr.			November	2°, 20	1 ^V O ^{ar}	10:10 A. [™]		
	Examir		4a. Facility Name (if not institution, give s			4b. City, Town, or		,					
			8 Regester Avenu 5. Social Security Number 6. Secu		s. last birthday)	Balti If Under 1 Year	More If Under 24 Hrs.	8. Date of Birth	Ba	altin			
	Funeral Director		215-54-0312 Usual Residence of Decedent	X M 2 □ F 6		Months Days	Hours Min.	Dec. 9,	1949	9. Birth Co <i>ur</i>	place (State or Foreign htry) Maryland		
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	후	10a. State 10b. County	10c.	City, Town or Lo	cation					10d. Inside City Limits		
	Mary 28a-f otifie	Director	Maryland Baltimon	re	Baltimoı	ce					1 ☐ Yes 2 🕅 No		
	th the 3a or 1 be r	la I	10e. Street and Number			10f. Zip Code	010	10		itizen of What Country?			
	ems 2	Funeral	8 Regester Avenue	12. Was Decedent Ever in	U.S. 13. V	Vas Decedent of His	212 spanic Origin? (Spe	cifv Yes or No-	U.S.		can Indian,		
ဖွ	ter de , or it	by F	1 Never Married 2 M Married	Armed Forces? 1 ☐ Yes 2 X No	li	f Yes, specify Cubar	, Mexican, Puerto	Rican, etc.)	Blac	k, White,	etc.		
ဗ္ဗ	ursaf tural" al Exa	ted	3 Widowed 4 Divorced	If Yes, Give Year or Dates.		I ☐ Yes 2 🔀 No			Specify:	Whi	te		
15	72 ho n "nai ledica	nple	15. Decedent's Ed (Specify only highest grad	de completed)	(Give I	lent's Usual Occupa kind of work done do		ng 10	6b. Kind of Bu	usiness In	dustry		
77	vithin jiene. er thau	Specify: Will Specify: Wil											
b	filed valued by all Hyg	Be	17. Father's Name (First, Middle, Last)					(First, Middle, Ma					
ylaı	ld be Ment: iarked	မ	Edward Michael S	imon, Sr.			Justine	Putcha	conis				
Nar	and 2 should t Health and Me tem 27 is marl ther traumation	3	19a. Informant's Name/Relationship (Type			ng Address (Street a		Code)					
e,	and 2 Health tem 2		Patricia R. Simon 20a. Method of Disposition		8 Re	gester Av			Maryla: Oc. Location -		21212		
nor	age 1 ent of nt: If ii y or o		1 ☐ Burial 2 X Cremation 3 ☐ I	Removal from State	cemetery, cren	natory or other place)			-			
Baltimore, Maryland 21215-0036	mit. Poartme	Ī	21. Signature of Funeral Service License	JOE		nt Cremat Name and Address	/-				Maryland		
m	permi Depar Impor any ir			Nane		M1tchell- 6500 Yor	wiedeield k Road 1	l Funeral Baltimore	Home, Mary	Inc	21212		
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell—Wiedefeld Funeral Home, Ir 6500 York Road Baltimore, Marylar 23a. Part 1. Eyer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line												
***	Physician/		Immediate Cause (Final disease or condition	Suiside	Guns	hotwoo	und to	head			Interval Between Onset and Death		
	Medical Examiner		resulting in death)	Due to (or as a conse	equence of):			250					
	13.5	Jer.	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	equence of):		-			-			
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury	`	, ,								
de	be executed sician and burial-transit	EX	that initiated events resulting in death) Last	Due to (or as a conse	equence of):								
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Box 6876	requires that the death certificate been signed by the attending physhould be detached for use as the	Physician/Medi	IF FEMALE:	3c. If yes, outcome of pred	Inangy				1				
X	ath ce attend for us	cian	in the past 12 months?	1 Live Birth 2 F 4 Pregnant at time of	etal death 3	Ectopic pregnancy Other (specify)			23d. Dat	te of deliventh	ery Day Year		
M	the de ny the ached	hysi	1 Yes 2 No 9 Unknown	9 Unknown					<u> </u>				
<u>P</u>	that tined b	by P	Part II. Other significant conditions con	ntributing to death but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	cco use contr	ibute to th	ne cause of death?		
ds,	quires en sig ould b	ted						1 🗆 Yes	2 🗆 No	3 Prol	bably 4 Unknown		
CO	law re nas be s 2 sh	Completed						24a. Was an autopsy	p	prior to co	psy findings available impletion of cause of		
Re	: The icate I	Cor						performe 1 \(\text{Yes} \) 2	03 0 No 1	leath?	2 No		
ţ	sician certifi irector	Be c	25. Was case referred to medical examiner? 1 ▼ Yes 2 □ No	ospital:		Other	ce of Death (Check				-		
<u></u>	g Physer this eral di	e: <u>1</u> 0	27. Manner of Death	1 Inpatient 2	28b. Time of	28c. Injury	4 □ Nursing Horat	me 5 Residence 28d. Describe how	e 6 U Othe	er (Specify ed Stat	2,76		
Division of Vital Records, P.O.	anding ath. rr: Afte	Certificate:	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury 1010 A	M 1 □ Y		junshatw		hea	9		
NS.	r Atte ter de irecto	ertil	3 Suicide 6 ☐ Could not be 4 ☐ Homicide determined			et, factory, office		28f. Location (Stree City or Town, S		r or Rural	Route Number,		
٥	oital o	SalC		28e. Place of Inj At building, etc. (Spec									
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. with Puneral Director, each and the Funeral Director, page 2 should be detached for use as the completed filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 Medical Examin	cian: To the best of my kno er: On the basis of examinate Practioner: To the best of	tion and/or investi	igation, in my opinion	, death occurred at	the time, date and p	lace, and due	to the car	use(s) and manner stated.		
	To the To the Complex		29b. Signature and title of certifier))		29c. License	number	29d	. Date signed	(Month, I	Day, Year)		
		1	Harrytte MV	Deputy		0186	107	N	ovemb	<u> ૧૧૧ ૩</u>	,2010		
	6		30. Name and address of person who co	mpleted cause of death (It	em 23a) (Type, P	crint)	11-2						
	Stat	e e	31. Date filed (Month, Day, Year)			cr. Luthen	OTHE Z	1073					
	Registr:		NOV 0 4 2010 /2	32. Registrar's Sig	an Kal								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 31,2^{Year} Physician/ Joseph C. Smeton 0540 a M October Medical 4b. City, Town, or Location of Death Towson4a. Facility Name (if not institution, give street and number) **Examiner** 4c_County of Death Baltimore Gilchrist Center Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Country Hours 1 DM 2 DF Oct. 11, 1935 75 213-30-7221 Director Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Completed by Funeral Director Rosedale Baltimore MD 1 ☐ Yes 2X No 10f. Zip Gode 21237 10g. Citizen of What Country? 5046 Springhouse Circle 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: White 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Salesman 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Jerry's Chev marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, and Mental ပ္ Frank J. Smeton Frances Anna Lukas 19a. Informant's Name/Relationship (Type, Print) ship (Type, Print)

Cataldi /daughter 5046 Springhouse Circle Balto. MD permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau once. 21237 Valerie 20b. Place of Disposition (Name of 20c. Location - City or Town, State 11/3710 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Gardensof or the rolling Rossville MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ame and Address of Facility 300 Mace Ave. Balto. <u>Connelly Funeral Home of Essex 2</u> Colud 21221 23a. Part 1. Enter the disease, or conshock, or heart failure. List on plications that caused one cause on each lin eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician/ Metastalic disease or condition Leaves Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Li retail 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Yes 2 No ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ☐ Yes 2 🗷 No 1 ☐ Yes 2 ☐ No I or Attending Physician: after death. **Division of Vital** completed filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) 2 🔀 No P 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Cher (Specify) after death. Director: After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 🗌 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) D71040 31 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 ARATHI N Charles ST Tousson MD 6701 KUMAR

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

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			For State	State of Maryla		rtificate of i		_	2111	0 34519
			Registrar 1. Decedent's Name (First, Middle, Last	t)		Tuncate of I	Dealli	2. Date of De	Reg. No.	
	Physicia		Doris J. S	'				Month	31 Day 2018	3. Time of Death
	Medic Examir		4a. Facility Name (if not institution, give	street and number)	•		r Location of Deat	h	4c. County of I	
)		Franklin Square H	10 spital Cent	er	Rosedo	ile		Battimo	
	Funeral		 Social Security Number 6. Se 	7. Age (In yr.	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		h 9. y, Yea <i>r</i>)	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent		93 Yrs.			March 2	22,1917	MD
	and show	or	10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
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	a or 2		10e. Street and Number	_		10f. Zip Code			10g. Citizen of Wha	t Country?
	within 72 hr urs after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Funeral	710 Kingston				21220		USA	
	r deal		11. Marital Status 1 🗶 Never Married 2 🗌 Married	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)		American Indian, Vhite, etc.
980	s afte al", c	d by	3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates.		1 ☐ Yes 2 🙀 No	Specify:		Specify:	White
Maryland 21215-0036	heur hietu dieal	Completed	15. Decedent's Ed	lucation	16a. Dece	dent's Usual Occup	pation		16b. Kind of Busine	
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auc	e filed ntal Hy ed oth event	To E	17. Father's Name (First, Middle, Last) Frederick St	uobor Sr			18. Mother's Nar		Maiden Surname)	
Σ	should and Me is mari	[19a. Informant's Name/Relationship (Type		10h Maili	no Addreso (Ctront	L		O't T Ot-1-	7'- 0-4-1
	2 ± 2 ±		Mary Barbour /	·	1115	0 Chamb	ers Cou	rai Route Numbei 1 rt Uni 1	r, City or Town, State B Wood	stock MD
Ē,	1 and of Heal item		20a. Method of Disposition	20b	. Place of Dispo	osition (Name of		Date	20c. Location - City	or Town, State
Baltimore,	permit. Page 1 Department of Important: If it any injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	Oak La	matory or other place. Wn Ceme	tery 11	/2/10	Baltim	ore MD
att	permit. Departr Importa any inju		21. Signature of Funeral Service License	» <i>D</i>	2:	2. Name and Addre	ss of Facility 3	00 MAC	- Ave. B	alto. MD
m	20 E # 9		Patries R	Ten			Funera	.l Home	of Esse	x 21221
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- 1	hysician/		Immediate Cause (Final disease or condition	MVOCARdia	1 Info	archon.				Onset and Death
-	Medical Examiner		resulting in death)	Due to (or as a conse	equence of):					
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9/89	death certificate ne attending phy: ed for use as the	by Physician/Med	IF FEMALE:							
Š Š	th cer ttendi or use	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1 ☐ Live Birth 2 ☐ Fe	etal death 3		су		23d. Date of	
	e dear the at hed fo	ysic	1 Yes 2 No 9 Unknown	4 ∐ Pregnant at time o 9 ☐ Unknown	of death 5 L	Other (specify)			Month	Day Year
7. O	hat the	h h	Part II. Other significant conditions con	ntributing to death but not r	esulting in the u	underlying cause giv	ven in Part I.	23e. Did to	bacco use contribute	e to the cause of death?
Š,	ires the signer is signer if t	g b			_			1 🗆 \		Probably 4 🗆 Unknown
or o	requiper shou	Completed						24a. Was a	n 24b. Were	autopsy findings available
e e	he lav te has age 2	m o				· · · · · · · · · · · · · · · · · · ·		autop perfor	sy prior death	to completion of cause of
Vital Records,	an; T rtifica tor, p		25. Was case referred to medical			26. Pl	ace of Death (Chec	· -	2 ☑ No 1 □	Yes 2 No
5	nysici nis ce direc	10 E	examiner? 1 ☐ Yes 2 ☑ No	lospital: 1 Inpatient 2	☐ ER/Outpatier	nt 3 🗆 DOA Othe	er: 4 Nursing H	ome 5 Resid	ence 6 \square Other (S)	pecify)
DIVISION OF	ng Pt		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	y at	28d. Describe ho	ow injury occurred	
	tendi Jeath. Ior: A the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be			M 1 🗆	Yes 2 ☐ No			
<u>≅</u>	or At after c Direct in by	Cert	4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec.		eet, factory, office		28f. Location (Si City or Town		Rural Route Number,
ָ ב	spital ours heral filled		29a. Certifier 1 Certifying Physic	cian: To best of my kno	wledge death of	occured at the time	date and place a	nd due to the cau	co(c) and manner as	etatod
:	To the Hospital or Attending Physician: The law requires that the death certificate in within 24 hours after death. Within 24 hours after death. Completed filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 L Medical Examin	er: e basis of examinati	ion and/or invest	tigation, in my opinic	on, death occurred a	at the time, date an	nd place, and due to the	ne cause(s) and manner stated.
1	vithin to the comp		29b. Signature and title of certifier		.,	29c. License			29d. Date signed (Mo	
				J conann>		poos	5034		10/31/20	10
	4		30. Name and address of person who co	mpleted cause of death (Ite	em 23a) (Type, F	Print)	201	-11 ^	10000	
			DR JUCQUES CONCY	May, 9000 FR	anklin	1 Square	DKING B	altimore	MD 2123	04
	Stat Registra		31. Da NOV 104 02010	32. Registrar's Sign	Park	•				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene_ Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** DBERT 2010 NOVEMEROUN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10m HOSPITAL WENTER? men Nonthints 8. Date of Birth (Month, Day, Yea OCt • 24 If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X** M 2□ F Months 219-18-3505 86 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits r items 23a or 28a-f show 10a, State Randallstown Baltimore MD 1 ☐ Yes 2% No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21133 8410 Charlton Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1**x x**es 2 ☐ If Yes, Give Year or Dates: 2 □ No 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 ò 1 □Yes 2 XXNo Specify: r than "natural", o <u>م</u> Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Guard Security 12th 7 is marked other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pauline Ehatt Robert C. Jr. ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8410 Charlton Road Randallstown MD 21133 Anita Schutz /wife 27 Department of Health Important: If item 27 any injury or other to once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State Bayview Crematory 11/3/10 Baltimore MD 15 ☐ Other (Specify) 4 Donation 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signature / Funeral Service Licensee Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final DEPSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** MEUNIANIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or his a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, burial-trar Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 No 3 Probably 4 Junknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No -24a, Was an 1 ☐ Yes 2 ☐ No 2 . Was case r erred t medical examiner? director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending n 24 hours after death.

e Funeral Director: Af investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical within 24 hou To the Fune completely fi (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of gertifier

DHMH 17 Rev 1/2001

State Registrar CRIANDO

31. Date filed (Month, Day, Year)

MY

Nonthwest Hospita

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Contany

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ October 24 Pay 2010 11:24 P M Daniel Warren Sharpe Medical 4a. Facility Name (if not institution, give street and number) 4b City Town or Location of Death **Examiner** 4c. County of Death Carroll Hospital Center Westminster Carroll 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In vrs. last birthdav) 9. Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. March, Day, Year) 941 215-38-4626 69 Director Usual Residence of Decedent f show 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Westminster MD Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21157 113 S. Ralph St. within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? 11. Marital Status unk 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation unk 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) unk Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event ones. 18. Mother's Name (First, Middle, Maiden Surname) unk17. Father's Name (First, Middle, Last) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jerry Byrd - friend PO Box 1254; Westminster, Maryland 21158 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1
Burial 2 Cremation 3 Removal from State 4 □ Donation 5 ₺ Other (Specify) in state 22. Name and Address of Facility State Anatomy Board Signature of Eureral Service Licensee Ronald S Wad Wirector. 655 W. Baltimore Street; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ pen Oustrol disease or condition 40415 Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Exami resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Day 5 Other (specify) Year Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed?
Yes 2 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ₺ No 욘 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No. Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

Registrar

29b. Signature

Robert

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

410

. Registrar's Signature

Kass

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Malcoln

29c. License number

C

Westminster.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician October 19 2010 11:15 PM MacKenzie Anne Stuck /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 806 Merridale Blvd. Mt. Airy Carrol1 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, pril 27 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Washington 1 □ M 2 🛛 F April 1997 13 Director 538-37-4458 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show ?? is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examination at the notified at Director MD Carrol1 Mount Airy 1 ☐Yes 2KINo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 806 Merridale Boulevard 21771 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: ò 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "n any Injury or other transmitted." Elementary/Secondary (0-12) College (1-4or 5+) student education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Steven Douglas Stuck Susan E. Koehn ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan E. Stuck - mother 806 Merridale Boulevard; Mt. Airy, MD 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4⊠ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licer Ronald S 22. Name and Address of Facility State Anatomy Board Wade, 655 W. Baltimore Street; Baltimore, MD 21201 23a. Part i Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final . Physician Medulloblastoma year disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760, physician Physician/Medical the use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 ☐ Other (specify) P.0. the 9 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, <u>ک</u> 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 2**X** No 2 🗀 No 1 □Yes 1 ☐ Yes Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one)

Registrar

State

29b. Signature and tiple of certifier

dress of person who completed cause of death (Item 23a) (Type, Print) Cohen

29c. License number

041444

041444 October, 25, 2010

23a) (Type, Print)

CMSC-800; GOO NORTH WELLE SWEET Keltenore Way End

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	State of Maryland / Department of Health and Mental Hygiene	2

orothea Sue S	_	1- For State	Maryland / E	Department of Certificate of		d Mental H		2010 ag. No.	34523				
Physici	an/	Registrar 1. Decedent's Name (First, Middle,Last)					2. Date of Deal	th	3. Time of Death				
Medical Exami	ner	Dorothea Sue Stan					Month October 1	Day Year 4, 2010	1930 hrs				
		4a. Facility Name (if not institution, give str 26012 Brigadere Place	reet and number)	4	b. City, Town, or I Damascus	Location of Death		4c. County of Dea Montgomery	th				
Funeral Director		5. Social Security Number unk 6. Sex	7. Age (li	n yrs. last birthday) 64 Yrs.	If Under 1 Year Months Days	If Under 24Hrs Hours Min	_	10/5 Fore	irthplace (State or UNKign ountry)				
		Usual Residence of Decedent											
w any		10a. State 10b. County		c. City, Town or Locati	on				10d. Inside City Limits 1 Yes 2 X No				
Maryland 28a-f show d at once.	햦	MD Montgome 10e. Street and Number	ГУ	Damascus	10f. Zip Code			ng. Citizen of What Co					
21215-0036 Join with the Maryland Mental Hygiene. Mental Hygiene. marked other than "natural", or items 23a or 28a-f sho c event, the Medical Examiner must be notified at once.	Director	26012 Brigadere P			20872		,	USA	artu y :				
th wit tems 2	Funeral	11. Marital Status 12 1 Never Married 2 Married	2. Was Decedent Eve Armed Forces? U	er in U.S. 13. Was n.K. If Ye	s Decedent of Hisp es, specify Cuban,			14. Race - Ame White, etc.	rican Indian, Black,				
ter des		3 Widowed 4 Divorced If Y		No 1	Yes 2X No	specify:		Specify: wh:	ite				
5-0036 led within 72 hours after d Hygiene. other than "natural", or the Medical Examiner m	d by	15. Decedent's Education (Specify only h	Dates:	ted) 16a Decedent	nt's Usual Occupation (Give kind of work done lost of working life. DO NOT use retired)								
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21215-0036 uid be filed within 7 Mental Hygiene. marked other than	Be Co	17. Father's Name (First, Middle, Last)un	.k		1	8.Mother's Name	(First, Middle, N	Maiden Surname) UN	K				
2121 hould be fill and Mental F is marked ttic event, j	10 E	19a. Informant's Name/Relationship (Type	Print)	19b. Mailing	Address (Street	and Number or F	Rural Route Num	ber, City or Town, Stat	e, Zip Code)				
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Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event,		20a. Method of Disposition 1 Burial 2 Cremation 3 1		20b. Place of Disposi crematory or oth		etery,	Date	20c. Location - City o	r Town, State				
Baltir permit. P Departme Importa injury or	ł	4 Donation 5 X Other Specify: 1 21. Signature — Funeral Service Licensee	de Direc	tor 22. N	ame and Address	of Facility Sta	te Anat	omy Board					
E.E.G.E.OO		Semmille	Cle	6.	55 W. Bai	ltimore	Street;	Baltimore	, MD 21201				
Physician /Medical		23a. Party. Enter the disease or complicat failure. List only one cause on each li	ne.					est, shock, or heart	Approximate Interval Between Onset and				
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	ē	Sequentially list conditions, if any, leading to immediate Due	to (or as a conseque	ence of):									
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be expurial ourial	edical	AUNPENDED A	XUNPENDED AMENDED 23a, PII, 27, 28a-f, per ME g909 11.30.10 TT 23d Data of delivery										
Box 68760 e death certificate b the attending physi ed for use as the bu	N.	3b. Was decedent pregnant in the	3c. If yes, outcome of	in pregnancy	aldeath 3	Ectopic pregna		23d. Date of deliver	ry Day Year				
x 68 h certi	icia I	past 12 months?	Pregnant at time	of death	er (Specify)		noy	15	bay roa				
BO)	Physician/M	1 Yes 2 No 9 V Unknown											
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by ited in by the funeral director, page 2 should be detached.	è	Part II. Other significant conditions cor Cardiomegaly	tributing to death bu	t not resulting in the u	nderlying cause giv	ven in Part I.		bacco use contribute to					
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Vital Rec ysician: The l his certificate l director, page	Š	25. Was case referred to medical			26.Place o	of Death (Check			63 2 10				
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Divis	Certification:	3 X Suicide 6 Could not be 4 Homicide determined	28f. Location (S or Town, St Damascu	treet and Number or Roate) 26012 Br ste) MD	ural Route Number, City igadere PI								
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b	edical (29a. Certifier (Check only one) 2 Medical Examiner: One											
E 3 E 8	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signed (Mo	onth, Day, Year)				
		his ho.	N/S		O.C.M	I.E.		October 15, 2010					
	ľ	30. Name and address of person who comp Ling Li, MD Assistant Medi		(Item 23a) 111 Penn Street	. Baltimore M	1D 21201		· · · · · · · · · · · · · · · · · · ·					
St	ate	31. Date filed (Month, Day, Year)	32. Registrar's S		,			- ·					
Regist	rar	NOV 0 4 2010	The same of	At The									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lojury or other traumatic event, It. Modical Evantinal by notified at once. Baltimore, Maryland 21215-0036

Physicia /Medica Examine

Funeral Director

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

		 State Registrar 				Cer	titicat	e of l	Jeath			Reg. No.	0.0		
		1. Decedent's Name	e (First, Middl	e, Last)							2. Date of D				. Time of Death
hysicia		Aileen S	Schwart	zman						(Octobe:	$r 2 I^{ay}$	20 Ĭ or	9	:45 A M
/Medic				n, give street and nu	mber)		4b City	Town or	Location of	f Death		4c.	County of Dea	ath	
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							If Under		If Under	24 Hrs	8. Date of B	irth	T a Rii	rthplace	e (State or Foreign
ıneral		5. Social Security N		6. Sex 1 □ M 212 F	7. Age (In yrs.	Yrs.	Months	Days	Hours	Min.	(Month, L	ay, Year)	Ma	ountry)	
rector		218-22-9			82						Aug J,	1920	, IIa	тут	and
*	}	Usual Residence of 10a. State	10b. County		10c Cit	y, Town or Lo	cation							10d.	Inside City Limits
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j-g	5	FID	MOII	tgomery	ь	etnesua									
or 2	ire	10e. Street and Nur	mber	T #/	1.0		10f. Zip	Code 0852				10g. Citi:	zen of What C	ountry?	?
23a	<u>a</u>	2220 In	ickerma	n Lane #4	19			0032				0.5)A		
SE E	Funeral Director	11. Marital Status		12. Was Dece Armed Fo	edent Ever in U.	S. 13. \	Vas Dece	dent of H	ispanic Ori	gin? (Sp	ecify Yes or N Rican, etc.)	lo-	14. Race - Am Black, Whi		Indian,
or ite		1 Never Marri	ed 2□ Mar	ried 1 □Yes	2X No		l ∐Yes		Specify:	, , , ,	viloui i, oto.,		Specify: Wh		
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£.	F O	12		2	,	hou	sewi			0.	wn home	e			
ent,	Be C	17. Father's Name	(First, Middle,	Last)					18. Mothe	r's Name	e (First, Middi	e, Maiden	Surname)		
c ev		Edward Harold Sherman Mollie									Crysta	1			
marl	၉	19a. Informant's N	ame/Relations	chin (Time Print)		19h Maifir	a Address	(Street	and Numbi	er or Rur	al Boute Num	ber City o	r Town, State,	Zin Co	nde)
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ther the											Date		cation - City o		
or of		20a. Method of Dis 1 ☐ Burial 2		3 Removal from		Place of Dispo emetery, cren	natory or c	ther plac	(e)		Juic	200. 20	oution only o		, otato
ant:		4⊠Donation							i						
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If we make Examination that the notified at once.		21. Signature of Fu	neral Service	Licensee Ware	Arecto	r 22					ite Ana				
트등정		21. Signature of Funeral Service icenses Wade, Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street; Baltimore, MD 21201 23a. Part 1. Ever the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate													
		23a. Part 1. Enter t	he disease, o	complications that	aused the deat	h. Do not ent	er the mod	de of dyir	ng, such as	cardiac	or respiratory	arrest,		Ap	proximate terval Between
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or: /	cati	2 ☐ Accident 3 ☐ Suicide	investi 6 ☐ Could	igation not be			М		Yes 2 🗆	No					
irect n by	ıţį	4 Homicide	deterr	ningal 200, Flack	e of Injury - At he ing, etc. <i>(Speci</i>		eet, factor	y, office			281. Location City or 1	(Street an own, State	nd Number or i !)	Hural H	loute Number,
To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for u	O														
une ely fil	cal	29a. Certifier (Check only		ng Physician: To the Examiner: On the !											
he F	edical	one)	A		ner stated.			,,							
To t	Σ	29b. Signature and the of certainer 29c. License number 29d. Date signed (Mo								nth, Da	y, Year)				
		D26571 101261							10						
		30. Name and add	ress of person	who completed cau	se of death (Iter	n 23a) (Type.	Print)			•			1		
		Irvin Mizus 10605 Concord Street Ste 500 Kensington, MD 20895													
Sta	te	31. Date filed My			Registrar's Sign										
اد Registr		NOA	A -1 50	10 census	A.	di zu									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34525 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Paulino G. Santos October 0 2010 3:00 P.[™] Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 906 Windwhisper Lane Annapolis Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** 9. Birthplace (State or Foreign (Month, Day, 1 X M 2 □ F Hours Director Philippines 213-70-6323 June Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Maryland | Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ms 23a or must be r Funeral 906 Windwhisper Lane 21403 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates. 1955-76 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner ō ρ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: "natural", Specify: Filipino Completed 3 X Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Crane Operator U.S. Military Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Prenucio Santos Mercedes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Joseph Santos 906 Windwhisper Lane; Annapolis, MD 21403 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cemetery 10/2/2010 Baltimore, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue: Catonsville, MD 21228 21. Sign were of Juneral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Examiner Scuentially list outditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine brovascular accident Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L Fetal use.
Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) ____ signed by the atte in the past 12 months? Day Year Yes 2 No Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 🗌 No 3 🖫 Probably 4 🗌 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has obstructive pulminary performed' **Director:** After this certificate I in by the funeral director, page 260180 1 Yes 2 No Be (25. Was case examiner? 26. Place of Death (Check only one) 2 1 No Hospital Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury atural 5 Pendina work? 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cert NO0527 who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 51 6:25 AM 2010 NOVEMBER Medical 4a. Facility Name (if not institution, give street and number, or Location of Death 4c. County of Death 4b. City, Town. Examiner RANDALL HOSP RTHWES STOWN IMURE 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** 1 XM 2 □ F Months Days Min 027057 1938 72 Yrs. UKRAINE 213-35-5344 Director Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 Yes 2 No BALTIMORE REISTERSTOWN MD 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral USA 5 COLISTONE ROAD 21136 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. ģ 1 Never Married 2 X Married 1 Yes If Yes, Give 2X No 21215-0036 1 Yes 2 No Specify Specify: WHITE 3 Nidowed 4 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) GOVERNMENT Department of Health and Mental Hygier Important: If item 27 Is marked Attachment in Journal Age any injury or Attachment 4 ENGINEER Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ SHTERN ETTA KOGEN SAMUEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 COLISTONE ROAD, REISTERSTOWN, MD 21136 POLINA SHTERN/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State BALTIMORE HEBREW CEM : 11/3/2010 REISTERSTOWN, MD Benation 5 Other (Specify) 22. Name and Address of Facility uneral Sen Signatur SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition CARDIO VASCULAR HERSCI Physician/ ROTIC Medical resulting in death) Due to (or as a consequence of) **Examiner** Securedly list conditions, if any, leading to immediate cause. Enter Underlying wentially list conditions Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events physician and s the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Dav Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 廥 Division of Vital Records, Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Wunknown Completed . Were autopsy findings available prior to completion of cause of 24a. Was an prior to completio death? performed 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 100 ည 1 Inpatient 2 VER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manuar of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 2 | 3 | within 24 hours after deat To the Funeral Director, completed filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 29c. License numb NOVEMBER 2 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print EUAD ROTHEN 401 LOURT OUD 21117 32. Registrar's Si Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Migdle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0 4. WOA Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8. Date of Birth Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 📭 Min. Months Director Usual Residence of Deceder or 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 🗆 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes Baltimore, Maryland 21215-003 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
Alfe. DO NOT use retired) Decedent's Education Public (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ 055 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal 4 Donation 5 Other (Specify) 21. Sign at e f Funeral Service Licensee on EJ, JRIF 23a_Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner matosi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed eate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (of as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? this certificate Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 🗆 Çertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title 29c. License number 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Irina Mikit yanskaya 500 Upper Chisa peake 31. Date filed (Month, Day, Year) Registrar's Signatur State Registrar NOV 04 DHMH 17 Rev 7/2009

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			For State Registrar		State of Ivia	ai y iai iu	•	rtificat				iciliairiy	Reg. No			
П	Physicia	an	1. Decedent's Nan	ne (First, Middle, La	ist)							2. Date of De	eath Da	ay Year	3. Time of Death	_
	/Medic		Jane Ann Treadwell								Octobe	2 2	5 2010	10:24 PM	_	
)	Examin	er	$S \rightarrow A$								40	4c. County of Death				
-	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth							9. Birt	hplace (State or Foreign	,				
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	ems	Funeral Director	11. Marital Status		12. Was Decedent 8 Armed Forces?	Ever in U.S.	. 13.	Was Deced	dent of Hi	ispanic (Origin? (Sp	ecify Yes or N Rican, etc.)	0-	14. Race - Ame Black, White		_
20	or it	by Fi		ried 2 Married	1 ☐ Yes 2 ☐ N If Yes, Give	No		1 □ Yes		Speci				Specify: wl		
3-003b	filed within 72 hours after death with the Maryland Hygene. Wher than "natural", or items 23a or 28a-f show ent, the Markeal Evenime must be a cliffed at	ed b	3 ☐ Widowed	15. Decedent's E	Year or Dates:		16a. Dece	dent's Usua	al Occupa	ation			16b. h	Kind of Business/	Industry	
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altimor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural!" or items 23a or 28a-f show any injury or other traumatic event, the Maryland Experiment rust be nutified at once.			☐ Cremation 3 ☐ 5 ☐ Other (Special	Removal from State	Dull	metery, crer aney rial (e) ;	10/30	/10	Tim	onium, N	4D	
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			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death													
F	Physician		Immediate Cause (Final disease or condition resulting in death)													
الخرر	/Medical Examiner		resulting in death)	•	Due to (or as	a conseque	ence of);	4.							20/20	
		er	Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events b. The to cross a consequence of the conditions of the condit									WEERS	-			
D.	uted d ansit	Examiner	cause. Enter Und	erlying r injury	hen	atic	fai	ilur	e						Vears	
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	atten for us	sician/N	23b. Was deceder in the past 12	2 months?	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal o	death 3	Ectopic p		У			100	23d. Date of del Month	livery Day Year	
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	s that med b	by P	Part II. Other sign	ificant conditions	contributing to death be	ut not result	ting in the u	nderlying c	ause give	en in Par	t I.	23e. Did	tobacco	use contribute to	the cause of death?	
ρ _Ω	en sig	ed b										1 🗆	Yes 2	2 □ No 3 □ Pi	robably 4 Unknown	
ָ מ	law re as be 2 sho	Completed										24a. Was		24b. Were au	utopsy findings available completion of cause of	
ב = י	The cate h	Con										perf 1 □ Yes	ormed/	" I death?	2 No	
= =	ician; certifii ector,	Be	25. Was case refe examiner?	<i>†</i>	Hospital:				Othe		ce of Deat	h (Check only	one)			_
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5	iding th: After fune	tion	27. Manger of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Solution 28b. Injury at Work? 2 Solution 28b. Injury at Work? 2 Solution 28b. Injury at Work? 3 Solution 28b. Injury at Work? 1 Solution 1968													
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5	s afte	Certification:	4 ☐ Homicide building, etc. (Specify) City or Town, State)													
	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. Within 24 hours after death. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use		29a. Certifier (Check only	1 Certifying P 2 Medical Exa	hysician: To the best miner: On the basis o	of my know f examination	ledge, deat	h occurred	at the tin	ne, date	and place, death occur	and due to th	e cause	(s) and manner a	s stated. e to the cause(s)	
:	thin 2 thin 2 the I	Medical	one) 29b. Signature apo	title of certifier	and manner sta	ated.		290	. License	e numbe	er		29d D	ate signed (Mont	th. Dav. Year)	_
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	h		30. Name and add	lress of person who	completed cause of d	eath (Item :	23a) (Type.	Print) .	0/	1 0	0	11-	VL	1 11/0 0	o , cvev	_
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	Stat Registra		31. Date filed (Mor	1th, Day, Year)	32. Registra	y's Signat	arke !									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 2019b 11:25 Emil Tomaro Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Unk **Funeral** pril 27, Year 1934 1 ₺ M 2 🗆 Director 293-28-3189 76 Usual Residence of Decedent or 28a-f show notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Anne Arundel Annapolis MD 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o edical Examiner must be Funeral USA 21403 900 Van Buren Street 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? Large Forces) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status unk 14. Race - American Indian, Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white If Yes, Give Year or Dates 1 Yes 2 No Specify Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation UTIK 16b. Kind of Business Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Mc Elementary/Seconday (0-12) College (1-4 or 5+) unk unk Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) $\overline{\mathrm{unk}}$ ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2001 Medical Parkway; Annapolis, MD 21401 Anne Arundel Medical Center 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🖾 Other (Specify) in State 22. Name and Address of Facility State Anatomy Board Signa ur Funeral Service Licensee 655 W. Baltimore Street; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate bases. Enter underlying Cause (Disease or iinjury ner Due to (or as a consequence of): Exami the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and the for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Month Year 2 No 9 Unknown Unknown cate has been signed by a page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy perform death? Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ **X**o Other: 9 1 patient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending I **Director**: Ad in by the f 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifler (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) D0005829

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 U | U Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ LLIAM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Randallstown Seasons Hospice at Northwest Hospital If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **№** M 2 □ F Hours Aug 2, Day, 18922 Maryland Director 88 215-14-4109 Usual Residence of Decedent 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Ellicott City MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21043 USA 3020 North Ridge Rd; Apt 102 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Bace - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1942 Black, White, etc. 1 Never Married 2X Married ğ 72 hours after black 1 Yes 2 No Specify: If Yes, Give 1946 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) federal government print shop Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Page 1 and 2 should be ment of Health and Ment: Phillip Pryor Tonkins Lucinda Bellamy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Tonkins - wife 3020 North Ridge Rd Apt 102; Ellicott City, MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) in state cemetery, crematory or other place) 22. Name and Address of Facility State Anatomy Board Signature of Funcial Service Licensee Ronal of S Director 655 W. Baltimore Street; Baltimore, MD 21201 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ad line. 23a. Pa 1. Enter the disease, or complications that show, or heart failure. List only one cause on Immediate use (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence or) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Dav Pregnant at time of death ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy Yes 2 No 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 2 မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work 1 Yes 2 No Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

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30. Name and address of person who completed cause of death (item 23a)

31. Date filed (Month, Day, Year)

10-07986 Joseph Thaniel Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Joseph Thaniel Joseph Thaniel	MD. Od. Inside City Limits								
4a. Facility Name (if not institution, give street and number) Mercy Hospital 5. Social Security Number - time 6. Sex 217. Age (in yrs. last birthday) 217-62-0214 IMM 2 F 53 Yrs. 100. City, Town or Location 101. Size Code 21202 IMM March 10, 1957 102. Size and Number Immorphism I	lace (State or Unic								
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To a State 10b. County 10c. City, Town or Location 10c. City, Town or Location 10c. City									
MD Baltimore 10e, Street and Number 10e,									
401 E. Eager Street 11. Marital Status unk 12. Was Decedent Ever in U.S. Armed Forces? Unk 12. Was Decedent Ever in U.S. Armed Forces? Unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American White, etc. Specify: black 15. Decedent's Education (Specify only highest grade completed) 15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Usual Occupation (Give kind of work done Unit) 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) 19. Informant's Name/Relationship (Type, Pript) 20. Amethod of Disposition 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zire and Number of Cemetery, Coremation) 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zire and Number of Cemetery, Coremation) 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zire and Number of Cemetery, Coremation) 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zire and Number of Cemetery, Coremation) 20. Amethod of Disposition 1 Burial 2 X Cremation 3 Removal from State 20. Place of Disposition (Name of cemetery, Cremation)	X Yes 2 No								
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21. Signature of Funeral Service Licensee 22. Name and Address of Facility State Angtomy Roard Joseph H., Brown Jr., Funeral Home 2140.	N Fulton								
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Single Band Page 1 24a. Was an 24b. Were autop	sy findings available								
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The state of Death (Check only one) 25. Was case referred to medical examiner? Hospital: □ 1 ✓ Yes 2 □ No 1	2 No								
25. Place of Death (Check only one) examiner? 1 ✓ Yes 2 No No. 25. Place of Death (Check only one) Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other: 27. No. 27. No. 27. No. 28. Details follow the state of the									
27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred									
See Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural)	Poute Number City								
Company and the first part of	Notice Number, City								
은 병은 등 집 and manner stated.	ause(s)								
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, O.C.M.E. October 18, 2010	5: 1/								
30. Name and duess of person who completed cause of death (Item 23a)	Day, Year)								
Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	Day, Year)								
State 31. Date filed (Month, Day, Year) Registrar NOV 0 4 2010 32 Registrar's Signature	Day, Year)								

10-0 Gar

08304 y Alan Trogdon	Please Ty Si	pe or Print i tate of Maryla	n Black Indelible and / Department of Certificate of	Ink. Ensure All Copie of Health and Mental H of Death	ole.	2010 34532		
Physician/ dical Examiner	<u> Gary Alan Troqdon</u>	· ,			2. Date of Death Month Day October 30, 2	y Year 010	3. Time of Death 2318 hrs	
	4a. Facility Name (if not institution 93485 Little Cliffs Drive		umber)	4b. City, Town, or Location of Death Hollywood		4c. County of Dea St. Mary's	th	
Funeral	5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs	- 1.61	M/DD/YYYY) 9. B	irthplace (State or	

Director

Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Directo

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

	328-52-2702										MO			
	Usual Residence of Decedent													
	10a. State	10a. State 10b. County 10c. City, Town or Location										side City Limits		
Þ	MD	St Mary's	y's Hollywood							1 Yes 2 XXNo				
Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What C									Country?				
0	43485 Litt	le Cliffs	Rd	20636						USA				
Funeral	11. Marital Status	ed 2 X Married	13. Was	Decedent	of Hispanic O	ngin? (Spe	cify Yes or I	No-	- 14. Race - American Indian, Black, White, etc.					
Fur		_	1 _{XX} Yes 2		If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					wille, etc.				
ð	3 Widowed		If Yes, Give Year or Dates:		1 Yes 2 X No specify:						Specify: White			
ted	Elementary/Seco		nly highest grade comp College (1-4 or 5+	during most of working life DO NOT use setter the					16b.	16b. Kind of Business/Industry				
[5]								0.11						
									College					
Be (Jimmy J. Trogdon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State													
To									State, Zip Cod	e)				
	Donna Sue	Trogdon	Mother				Ave, Oz					,	-,	
	20a. Method of Disp			20b. Place o	of Disposit	ion (Name	of cemetery,		Date	20c.	20c. Location - City or Town, State			
	4 Donation 5		xx Removal from State	Clear				11-6-	2010	Sn	ringfiel	d. MO		
i	21. Sign up of Fur	eral Service Acer	se O		22. Na	me and Ac	dress of Facil	tv		1 4				
0.4	K. Gregory	Fink	PU1118		F 1	ink hur 26 Crai	neral Hor In Hwy S	ne, P.A Glen	Burnie	e. MD	21061		- 4	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only a cardy to each line. Approximate Interval													
	failure. List only in cause in each line. Immediate Cause (Final disease a. Gunshot Wound of Chest Between Onset and Death Death													
	or condition resulting in death) Due to (or as a consequence of):													
اير	Sequentially list conditions, b													
Ę.	If any, leading to immediate Due to (or as a consequence of): cause. Enter Underlyin Cause. Clisease or injury that lightled.													
xan	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):													
삚	d													
흻	X UNPENDED	X	AMENDED 23a	,27 , 28a	-f di	k								
	IF FEMALE: 23b. Was decedent p	regnant in the	23c. If yes, outcome	of pregnancy						23	d. Date of deli	of delivery		
.ia.	past 12 months?		1 Live birth Pregnant at tim	ne of death _	\equiv	I death		ic pregnanc	У		Month	Day	Day Year	
ysi	1 Yes 2 No 9 Unknown Unknown													
=	Part II. Other signifi	cant conditions	contributing to death b	ut not resulting	in the un	derlying ca	use given in P	art I.	23e. Did	tobacco	use contribute	to the cause	of death?	
Q Q						_			1 Ye	s 2 🗸	2 No 3 Probably 4 Unknown			
e									24a. Was	-			ings available	
틹	performed? death									of cause of				
ပို့ -	25. Was case referred to medical 26.Place of Death (Check only one)									2 No				
ŭΙ	examiner?	Ho	ospital: 1 Inpatient	2 ER/Ou	tpatient		Other	Nursing H		Pesido	nce 6 🗸 Ot	hor: Soona		
2	1 ✓ Yes 2 27. Manner of Death	No	28a. Date of Injury	28b. T	ime of Inju		Injury at Worl		d. Describe			rier. Scerie		
흲	- 1 1	5 Pending	(Month, Day, Year)		50 PI	1	Yes 2			•	•	_	1	
<u>[2</u>	2 Accident	Investigation 6 Could not b	28e Place of Injury		-			_			vas sho		Number City	
E	4 X Homicide	6 Could not b determined	(Specify) Hou		,				or Town,	State) 4	13485 L	ittle	Cliffs	
티	20a Cartifier	ertifying Physicia	n: To the best of my kr		th occurre	d at the tim	e, date and ni				Lywood , d manner as s			
	one) 2 V	ledical Examiner:	On the basis of examin	ation and/or in	vestigation	n, in myopi	nion, death or	curred at th	e time, date	and pla	ce, and due to	the cause(s)		
\$	29b. Signature and til		and manner stated.			29c. Lie	cense number		-	29d. [Date signed (A	Month, Day, Ye	ear)	
	Ulu	ed2				0	.C.M.E.			Octo	ber 31, 20	10		
-	30. Name and addres	s of person who co	ompleted cause of deat	h (Item 23a)			-							
Ana Rubio MD. Assistant Medical Examiner 111 Penn Street Baltimore MD 21201														

State 31. Date filed (Month, Day Year)
Registrar NOV 04 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar	of Maryland / De C	partment of He e <i>rtificate of De</i>			2010	34533		
Physic	ian/	1. Decedent's Name (First, Middle, Last)	1			Date of Death Month	Day Year	3. Time of Death		
Med \ Exam	ical	William 4a. Facility Name (if not institution, give street and nu	Vulgas	4b. City, Town, or Lo	ocation of Death	November		10:45p ^M		
) LXaiii	IIIGI	1300 Dundalk Ave.		Ba	ltimore		N/A	4		
Funera Directo		5. Social Security Number 6. Sex 1 1 M M 2 1 F	7. Age (In yrs. last birthday	y) If Under 1 Year I Months Days	f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthp Count Penns	lace (State or Foreign ry) Sylvania		
nd how	٦	Usual Residence of Decedent								
Maryla 28a-f s otified	irect	Md. N/A		Balti	more			1 🔀 Yes 2 🗌 No		
with the s 23a or 3 ust be no	Funeral Director	1300 Dundalk Ave.		10f. Zip Code	21224	100	g. Citizen of What Count USA	try?		
Iryland 27215-UU36 uld be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	र्व	Armed F	orces? 2 No ive	3. Was Decedent of Hisp If Yes, specify Cuban, 1 Yes 2 W No	anic Origin? (Spe Mexican, Puerto I Spec <i>ify:</i>	cify Yes or No- Rican, etc.)	14. Race - America Black, White, e Specify: Whit	tc.		
5-0 2 hour "natur	plete	15. Decedent's Education (Specify only highest grade completed	16a. Dec	cedent's Usual Occupation we kind of work done duri	on ina most of worki	na 16	ustry			
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam	Completed			DO NOT use retired) Steel Work	-		Steel			
and 21 e filed with ntal Hygier ed other t	To Be	17. Father's Name (First, Middle, Last)	~	1/	8. Mother's Name	(First, Middle, Mai				
Marylanc should be file and Mental I is marked o	ľ	Steve Vulgaraki 19a. Informant's Name/Relationship (Type, Print)		illing Address (Street and	Number or Rura	Anna Za		ode)		
P, MG Ind 2 st lealth a im 27 is			egiver 13	00 Dundalk						
Baltimore, Marylar permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If iten 27 is marked any injury or other traumatic en		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)	n State <i>cemetery, cr</i>	position (Name of rematory or other place) NO Cemtery	Novem 5,	ber	c. Location - City or Tov indalk , Mary.			
balt permit. Departi Import any inj		21. Signature of Funeral Service Licensee	noller.	22. Name and Address of Connelly F	uneral I	Home Of D	undalk, P. <i>I</i>	A. 21222		
ŧ		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between								
Physician Medica		Immediate Cause (Final disease or condition resulting in death) Onset and Death Onset and Death								
Examine		Sequentially list conditions, b.								
rted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or ininjury that initiated events c.	(or as a consequence of):							
rate be executed physician and the burial-transit	ia EX	resulting in death) Last Due to	(or as a consequence of):							
froate b g physical as the b	Medical	d								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months?	itcome of pregnancy Birth 2 Petal death 3 gnant at time of death 5 known			23d. Date of deliver	Y Day Year			
that the	by Ph	Part II. Other significant conditions contributing to	death but not resulting in the	e underlying cause given	in Part I.	23e. Did tobac	co use contribute to the	cause of death?		
rdS, equires een sig				No 3 ☐ Probably 4 ⊠Unknown						
HECOTOS, The law requires ate has been signage 2 should b	Completed					24a. Was an autopsy performed	prior to com death?	sy findings available inpletion of cause of		
VITAI ysician: s certific director,	Be	25. Was case referred to medical examiner?	_	Othor	of Death (Check	only one)		200.2		
ding Phys ding Phys h. After this funeral di	cate: To	1 Inpatient 2 ER/Outpatient 3 DOA Union 4 Nursing Home 5 Kesidence 6 Other (Specify)								
or Attendir after death. Director: After de alth.	Certificate:	3 Suicide 6 Could not be 28e. Place	e of Injury - At home, farm, s ing, etc. (Specify)					(Street and Number or Rural Route Number, own, State)		
le Hospita n 24 hours le Funera	Medical	29a. Certifier 1 Certifying Physician: To the (Check 2 Medical Examiner: On the bath only one) 3 Certifying Nurse Practioner.	sis of examination and/or inve	estigation, in my opinion, o	death occurred at	the time, date and p	lace, and due to the caus	se(s) and manner stated.		
To the withing the complete co		29b. Signature and title of certifier	m to ha	29c. License nu			Date signed (Month, Da			
		30. Name and address of person who completed gau	se of death (Item 23a) (Type,	Print)	65249		Tickel Fin	petral		
2		31. Date filed (Month, Day, Year)		OFAStern	Ave Bo	Honore	mort	VSS		
Sta Regist		NOV 0 4 2010	Registrar's Signature	Willey .						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-34534 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 2010 William Harry White 6:15a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore 1713 Carroll Avenue Halethorpe 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🖾 M 2 🗆 F Months Mary land Director 218-36-7197 70 Feb Usual Residence of Decedent 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City. Town or Location Director 10d. Inside City Limits ral", or items 23a or 28a-f sl Examiner must be notified Maryland Baltimore Halethorpe 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21227 1713 Carroll Avenue United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, rmed Forces?

☐X Yes 2 ☐ No 1957-Black, White, etc. þ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Divorced Specify: Completed 1965 White event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene.

27 Is marked other than retraumatic event, the Mental Elementary/Seconday (0-12) College (1-4 or 5+) Service Station Attendant Gas Station Be altimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William G. Beatrice Fisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau George R. White, Sr., Brother 1004 Fitzallen Road, Glen Burnie, Maryland 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State Metro Crematory, Inc. 11/2/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Aman a Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Interval Between Immediate Cause (Final Onset and Death Pnysician/ Corchar disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 attending ph IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month 1 Yes 2 L 9 Unknown been signed by the should be detached Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, OM, HTN, AGIB Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24a. Was an 24b. Were autopsy findings available s certificate has b lirector, page 2 s prior to completion of cause of death?

1 Yes 2 No performed? 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗷 No 1 🗌 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 X Residence 6 Other (Specify this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 XNatural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier King Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 51811 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Thomas Ghiorzi 1120 N. Rolling Road, Baltimore, Maryland 21228 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

NOV 04 2010

AMEND #27,28A-F, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 John W. West 3 Nov. 2:26 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery House Casey Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 X M 2 🗆 F Months Hours 95 Days **Director** 011-09-5486 Massachusetts Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County Director 10c. City. Town or Location 10d. Inside City Limits MD Silver Spring Montgomery 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20910 2201 Colston Dr., USA Apt.#511 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. Completed by 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: "natural", 3x Widowed 4 □ Divorced Specify: White item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha College (1-4 or 5+) Stocks & Bonds Salesman / Broker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles James West Alice Woodman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christopher M. West, Son 1496 Kimblewick Rd., Potomac, MD 20854 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place any injury or Metro Crematory, Inc. 11/04/2010 4 Donation 5 Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Rd., Baltimore, MD 21228 299 Frederick Rd., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Intracranial Hemorrhage disease or condition resulting in death)) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Litter Uniderlying Cause (Disease or iinjury Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDICAL EXAMINER use as the burial-transit law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy Por in the past 12 months?

1 Yes 2 No 4 Pregnant at time of death g Unknown Month Yes been signed by the should be detached 1 ☐ Yes ∠ L 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has funeral director, page 2 autopsy Hospital or Attending Physician: The l 24 hours after death. Funeral Director: After this certificate h perform death? 1 ☐ Yes 2 ☐ No Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1

Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 2 Other (Specify) Hospice ရ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury
FN (Month, Day, Year)
10/26/2010 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury FND 1 Natural 5 Pending 1 🗌 Yes 2X No 2 Accident Investigation 3:00 P SUBJECT FELL completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Bural Boute Number APT City or Town, State 2201 COTSON DR 4 Homicide determined NURSING HOME SILVER SPRING, MD 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, within 2 only one 3 K Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu 29c. License number 29d, Date signed (Month, Dav. Year) R-143201 30. Name and address of person who completed cause of death (Item.23a) (Type, Print) 6001 Muncaster Mill Rd., Rockville, MD 20855 <u>Debrah Miller.</u> CRNP 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 28, Physician/ JOSEPH WASSMAN 11:00PM Medical OCTOBER 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1514 CHESACO AVENUE BALTIMORE ROSEDALE If Under 1 Year | If Under 24 Hrs 5. Social Security Number Funeral 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1X M 2 | F 2 Month, Day Year) 219-32-9574 Director 73 MARYLAND Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at Funeral Director 10d. Inside City Limits MD BALTIMORE ROSEDALE 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 1514 CHESACO AVENUE items 23a 21237 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian ori Black, White, etc. ò 1 Never Married 2 Married 1 X Yes If Yes, Give 2 No Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: "natural", Completed 3 Widowed 4 XDivorced Specify: WHITE Year or Dates. 1958 – 64 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) MANAGEMENT BETHLEHAM STEEL Be 17. Father's Name (First, Middle, Last) should be file and Mental Fis marked ot 18. Mother's Name (First, Middle, Maiden Surname) JOSEPH WASSMAN ANNA (KASTINA) permit. Page 1 and 2 should be Department of Health and Men-Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TARA STARK/DAUGHTER 7018 BANK STREET BALTIMORE, MD Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛣 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) PARKWOOD CEMETRY 11-2-10 PARKVILLE, Signature of Funeral Service Licenses 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death Medical resulting in death) Due to (or as a consequence of) Examiner Dre (DISNT BULLAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine 24/10 that initiated events Due to (or as a consequence of). resulting in death) Last Physician/Medical certificate be Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Pregnant at time of death Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, Hospital or Attending Physician: The law requires cate has been signated by page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perforn death? 1 🗌 Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes ျ 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) filled in by the funeral Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completed fil 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed (Item 23a) (Type, Print) use of death 32. Registrar's Si

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar 34537 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 24, 2010 Berger Waggaman 9:40 P M Serena Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Oak Crest Care Center Parkville 4 8 1 Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F Days Hours March 2, Director Yrs 85 212-22-3517 Maryland Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits notified **Baltimore** 1 Yes 2 X No Maryland Parkville 10e. Street and Numbe 10g. Citizen of What Country? Medical Examiner must be 23a Funeral 8830 Walther Blvd. #118 21234 USA death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black. White, etc. 0 þ 1 Never Married 2 X Married ☐ Yes 2 X No filed within 72 hours after 21215-0036 1 ☐ Yes 2 X No Specify: If Yes. Give "natural", Completed 3 Divorced 4 Divorced Specify: White Year or Dates Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired)
 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) **02** the 12 Buyer Retail traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) and Mental I ဂ္ pe John Albert Berger Serena Schoenberger should I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Page 1 and 2 Lewis W. Waggaman/Husband 8830 Walther Blvd., #118, Parkville, MD 21234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 11/4/2010 4 ☐ Dongtion 5 ☐ Other (Specify) Maryland Veterans Cemetery Owings Mills, Maryland 22. Name and Address of Facility
Lemmon_Funeral_Home of Dulaney_Valley_Inc. 10 W. Padonia Road, Timonium, MD 23a. Part 1. Friter the disease, or conclications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only in exause on each line. Interval Between Onset and Death Immedia Cau (Fi disease or co-cition resulting in death) (Final Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Dav Year been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Dementia, Vascular 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was a... autopsy performed? s certificate has b lirector, page 2 sl 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Sp 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practiceer: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and in armor as stated. 29c. License number 30. Name and address of person who completed ause of death (Item 23a) (Type, Print) WALTher Blod filed (Month, Day, Year) State

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 723 P Winter Egon 2010 Now am hen /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 318 Leeanne Road Essex Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 19 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year Hours Days Min 1 M 2 □ F 80 1930 Germany Director 120-24-3376 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene.

wit; if item 27 is marked other than "natural", or items 23a or 28a-f show and it of the than "natural", or other traumatic event, it is it was a unstructed it. 1 ☐Yes 2 ☐ No Director Essex Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Germany 21221 318 Leeanne Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married ^{Specify:}White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 🗓 No Specify. 2 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) International Paper Printer NA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Winter Unknown Margaret Kar1 ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1803 Larch Drive Edgewood, Maryland 21040 Ian K. Winter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) November 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page:
Department of Important: If any Injury or once. 4,2010 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) Bayview Crematory Inc. 21. Signature of Funeral Service Li W. Dabrowski/Chojnacki Funeral Homes P.A. 1005 Dundalk Ave. Baltimore, Maryland 21224 23a, Pirt 1. Inter the diseas s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or complication ause on each line shock, or heart failure. List only Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** 2784 lanates /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to for as a consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. physician Physician/Medical the as attending IF FEMALE: for use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 ☐ Other (specify) 1 ☐Yes 2 ☐No detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 → No Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 ho

To the Fune

completely f (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
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31. Date file (Month, Day,

eHill CT. Lutherville, Md 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

James Wiedenfe	eller	1- For State Certificate of Death		20	10 34530						
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		Johns Hopkins Bayview Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 1 If Linder 24Hrs. 8. 1									
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Baltimo permit, Page Department or Important: injury or ott	ı	21. Signatur Fun al price Licenses 22. Name and Address of Facility State	Anato	my Board							
E E G E O	ļ	655 W. Baltimore Str	eet;	Baltimor	e, MD 21201						
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respir failure. List only one cause on each line.	ratory arres	t, shock, or heart	Approximate Interval Between Onset and						
/Medical Examiner		Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Disease			Death						
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to	the cause(s	s) and manner as	stated.						
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	Š [29b. Signature and title of certifier 29c. License number	2	9d. Date signed	(Month, Day, Year)						
		Uf In Graff Mod O.C.M.E.		October 13, 2	010						
		30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell MD Assistant Modical Examples 1111 Boars Street Baltimars MD 21206									
Sta		Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day Year) 32 Registrar's Signature.									
Registra											

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 34540 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 7:35 P.M Genevieve Weigman October Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Westminster Dove House Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Days Hours Min May 20, 1922 88 Maryland Director 216-14-8659 Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🖾 No Maryland Anne Arundel Annapolis ò 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? items 23a Funeral 1237 River Bay Road death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. "natural", or ğ 1 Never Married 2 Married 2 🔀 No 1 ☐ Yes If Yes, Give Maryland 21215-0036 filed within 72 hours after 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
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1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 o 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has ral director, page 2: performed Yes 2 1 🗌 Yes funeral director. Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 🗌 Yes 욘 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence Other (Spec 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Sulcide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours a To the Funeral D Medical 29a. Certifie Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 2010 30. Name and address of person who comp cause of death (Item 23a) (Type, Print) WESTMINSTER, dis) 21 31. Date filed (Me State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 28, John Everett Wallace 2010 9:00 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Ellicott City Rehab Ellicott City Howard 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year **Funeral** 9. Birthplace (State or Foreign 1**X** M 2 □ F Months Days Hours Min. Country **Director** Yrs 215-16-5497 88 ept. 6,1922 Virginia Usual Residence of Decedent 10a. State 10b. County within 72 hours after death with the Maryland notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f MD Baltimore Baltimore 1 Yes 2X No 10e, Street and Number ō 10f. Zip Code must be r 10g. Citizen of What Country? Funeral 1230 Greystone Road United States items 2 12. Was Decedent Ever in U.S. Armed Forces? 1 □XYes 2 □ No 192 If Yes, Give 192 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Examiner ō þ 1 Never Married 2 X Married 1346 Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: "natural" 3 🗌 Widowed 4 🗆 Divorced White Specify. Completed Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be filed permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Elwood Wallace Bessie Whitney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Wallace / Wife 1230 Greystone Road, Baltimore, Maryland 21227 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Crownsyille Veteran Cemetery ▼ Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Nov.3,2010 Crownsville, Maryland Signature of Funeral Service Licen 22. Name and Address of Facility AMBROSE FUNERAL HOME, INC. 1328 Sulphur Spring Rd., Arbutus, Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cau Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ph_sician/ levolu ardio Vas Cular Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

A Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year by the 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? b Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Ves 2 No has this certificate 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Hospital: Other: 2 🗌 မှ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural iniury 5 Pending work / 1 ☐ Yes 2 ☐ No Àccident Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 1) 3064 anch Name and address of person who completed cause of death (Item 23a) (Type, Print) RIVEY MECK ROAD 201-

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician/ Month 07:10 AM 2010 Medical 4a. Facility Name (if not institution, give street and number)
Johns (Topkins Supress) Cure (4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Mary Cinc Utimor If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 8-2-192 1 🗆 M 2 🕅 F Days Maryland 215-14-0933 88 Yrs. Director Usual Residence of Decedent 28a-f show 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at Director 1 Yes 2 No MD Baltimore Co. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 435 Pembrooke Blvd 21224 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: Completed 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Maryland General Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the I Unit Manager Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ Dominic Baldassare Grace Tacchetti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Joseph Welzenbach (Son) Pembrooke Blvd Baltimore, MD20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) <u>11-5-10</u> Stanislaus Cem. Baltimore. 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licens Dundalk Avenue Baltimore, Approximate 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to for as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of Examir oronan physician and the burial-transit Cause (Disease or iiniury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 attending pl 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? Year 1 Yes 2 Li detached 9 Unknown β significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed d be det þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 N has death? certificate 1 Yes Division of Vital 25. Was case referred to medical or Attending Physician: funeral director, 26. Place of Death (Check only one) Be examiner? 2 No Hospital: Other: 1 Yes 1 Denpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of the funeral place of filled in by the funeral completed filled in by the funeral f (Month, Day, Year) Natural 5 Pending 1 Yes 2 | No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Hospital Medical 🖺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address decision who completed cause of eath (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Seculen

31. Date filed (Month, Day

Bay

new Care

Johns Hopkins

32. Registrar's Signature

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		For State	State of M	larylanc		irtment of I <i>tificate of</i>	Health and I	,	giene Reg. N2 0 1	0 34543		
		Registrar 1. Decedent's Name (First, Middle)	e. Last)		Cei	inicate of	Dealii	2. Date of Dea		3. Time of Death		
Physici			LKA	1	WALLIN			Month Nove-6	Day 3	Year 2:43 AM		
/Medic Examin		4a. Facility Name (If not institution					or Location of Death		4c. County			
		Sinai Hospital					timore			N/A		
Funeral		5. Social Security Number 112–36–4706	6. Sex 7. A	ge (In yrs. la 64	st birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birl (Month, Da 03/17/	h y, Year)	9. Birthplace (State or Foreign Country) ISRAEL		
Director		Usual Residence of Decedent	Λ	04				03/1//	1940	ISKALL		
show	_	10a. State 10b. County		10c. City,	Town or Loc	cation			10d. Inside City Limits			
he Ma 28a-f	Director	MD N/A		В	ALTIMO			1 √ Yes 2 No				
with t	Dir	10e. Street and Number 6209 BILTMORE	AVENILE			10f. Zip Code 21215	:		10g. Citizen of V			
filed within 72 hours after death with the Maryland Hygiene. Hygiene within "natural", or items 23a or 28a-f show ent, the Andical Examiner is ust be in tiffed at	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S	. 13. V	Vas Decedent of I	Hispanic Origin? (S	pecify Yes or No		e - American Indian,		
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e filec al Hyg l othe vent,	Be C	17. Father's Name (First, Middle,	Last)				18. Mother's Nam	ne (First, Middle,	Maiden Surnam	ne)		
ould b Ment arkec	일	MENACHEM MONA	AS HOUSEMAN				MIRIAM			ICHTO		
h and rish m		19a. Informant's Name/Relations				,	and Number or Ru			, ,		
1 and Healt tem 2	: 61	BLIMI BARKIN	DAUGHTER	20b. Pla	ace of Dispos	sition (Name of	LANE, AI	Date		RE, MD 21215 City or Town, State		
ages ent of nt: If it		1X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		cei	metery, crem	atory or other pla CHOT CEM		03/2010		LEM, ISRAEL		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan De artment of Health and Mental Hygiene. Important: If firem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its and call Examinations is as be notified at on.		21. Signature of Funeral Service		IIIXIX		Name and Addre				ROS., INC.		
E S E E S		Michael	KILICE		8	900 REIS	TERSTOWN					
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ding Physician: The h. h. After this certificate h funeral director, page	L:uo	27. Manner of Death 1 ☑ Natural 5 ☑ Pendin	28a. Date of Inj (Month, Da	ury ay, Year)	28b. Time of Injury	28c. Inju Woi			now injury occurr			
tendi leath. tor: A the fu	cati	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could i	ation				lYes 2□No					
or At after o	Certification: To	4 ☐ Homicide determ	inod 28e. Place of In	tc. (Specify)	ne, tarm, stre	et, factory, office		City or Tov		er or Rural Route Number,		
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with Vot	Σ	29b. Signature and title of certified				29c. Licens			_	d (Month, Day, Year)		
		1	3-	M. 4.		D5	9062		Novem	ber 3, 2010		
		30. Name and address of person	who completed cause of	death (Item 2	23a) (Type, F	Print)	R 11		11 2121	ber 3, 2010		
Sta	te	31. Date filed (Month, Day, Year)	32. Regist	rar Signatu	backer	Belvedere	134/11	more 1	121	,		
Registra	ar	NOV 0 4 2010	Lenny	1. 1	- 112-1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			_ State	Marylar		artment of F		d Mental Hy	/giene		
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	Physicia		Samuel J. Yacovissi					2. Date of Do	er 29, 201	Year	3. Time of Death
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	land show dat	ě	10a. State 10b. County	10c. Cit	ty, Town or Loc	cation				1	0d. Inside City Limits
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ary.	ould I		19a. Informant's Name/Relationship (Type, Print)		19h Mailin	g Address (Street a			City on Town C	24-4- 71- 0	
	d2sh altha 27is artra		Agnes Ruth Yacovissi Wife		i .	Roland Ave			-		·
ore,	permit. Page 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner. once.	10	20a. Method of Disposition	20b. F	Place of Dispos	sition (Name of atory or other place		Date	20c. Location -		
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	o the vithin o the comple		only one 3 Certifying Nurse Practioner To 29b. Signature and title of certifier	the best of my	Andwiedge, de	29c. License	time, date and p	ace, and due to the	29d. Date signed	nner as sta	led.
	->) Juny			0517			Nov	ISH	2016
	,	1	30 Name and address of person who completed cause of			nt)	1		<u>`</u>		~ ~ / ~
	6		Konit Gulati MD	3730	Falls	Kocid	Balti	more	MD 21	1211	
	Stat Registra		31. Date filed (Month, Day, Year) 32. Regi	strar's Signatu	ure	The state of the s					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ober 2:25H-W Carolyn A. Zimmerman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Battimore paint Agnes Hospita Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F 60 Hours Min. No (Month 2 Pay, Year) 949 Mary Tand **Director** 213-54-0636 Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🖺 No MD Baltimore Catonsville 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Funeral 5743 Edmondson Ave. United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2X No Black, White, etc. <u>چ</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: If Yes, Give Year or Dates Specify: White "natural", 3 Divorced 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Maryland State and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Certified Public Accountant Government 12 +4 other traumatic event, 17. Father's Name (First, Middle, Last) George N. Sievert 18. Mother's Name (First, Middle, Maiden Sumame) Mercedes M. Hittel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Janet M. Healey/ Sister 1601 Cynthia Ct., Jarrettsville, Maryland 21084 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or conce. Loudon Park Cemetery 1 X Burial 2 Cremation 3 Removal from State Oct.30,2010 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility AMBROSE FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee alic 1328 Sulphur Spring Rd., Arbutus, Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner roscleratic Cardiovascular Disease Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examin physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death signed by the a d be detached fi 1 ☐ Yes 2 L g ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has bage 2 s autonsv 1 Yes 2 No ☐ Yes of Vital 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Hospita Other: 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred eral Director: After filled in by the funer Natural 2 Accident 5 Pending 2 No 1 Yes Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, within 24 hours after d

To the Funeral Direct

completed filled in by 1 determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature

Registrar

DHMH 17 Rev 7/2009

State

Carolyn

Scaton

Raltimore

30. Name and address_of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

4

Mason

900

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ D2/0 October William F. Amann 2010 2:45 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Sanctuary at Holy Cross Burtonsville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Year) 916 1 **X** M 2 □ F Jan 24 Hours Director 213 07 4724 94 PA Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho. 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits 1 🗆 Yes 2 🖰 No MD Howard Ellicott City 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 9602 Longview Drive 21042 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1944–46 1 ☐ Yes 2X No Specify. 3 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Certified Public Accountant Federal Government Be 17. Father's Name (First, Middle, Last) 7 is marked ot 18. Mother's Name (First, Middle, Maiden Surname) Frank P. Amann Elizabeth Roberts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan A. Gainer/Daughter 9602 Longview Drive Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 KBurial 2 Cremation 3 Removal from State cemetery, crematory or other place injury or 4 ☐ Donation 5 ☐ Other (Specify) 10-23-2010 New Cathedral Cem. Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit Harry H. Witzke's Family FH Inc. M01044 4112 Old Columbia Pike Ellicott City, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final (Inysicient disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or iinjury signed by the attending physician and I be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Year Day ☐ Yes ∠ _ ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Donknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy autops, performed Ves 2 this certificate 1 ☐ Yes 2 ☐ No Phospital or Attending Physician: 24 hours after death.
Funeral Director: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Other: ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 | Medical Examiner. On the basis of examination and on invosingation, it my opinion) depends a place, and due to the cause(s) and manner as stated.

3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0069829 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smith Avenue, Suite 203 2835 31. Date filed (Mon State 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

RELAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 7:55 PM ALLISON III October GEORGE WILLIAM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) Aug. 19, 1953 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 😿 M 2 □ F Hours Virginia 57 **Director** 228-82-6987 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director must be notified 28a-f 1 🗌 Yes 2 🔀 No Maryland Montgomery Damascus 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ō 23a U.S.A. 25225 Conrad Court 20872 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married ö Completed by be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White Yes. Give 3 Divorced 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) event, the Engineer Electronic of Health and Mental Hygie item 27 is marked other other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ George William Allison, Jr. Kitts Barbara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan V. Allison - Wife 25225 Conrad Court, Damascus, Maryland 20872 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Rurial 2X Cremation 3 ☐ Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematorium 10/19/10 Alexandria, Virginia 21. Signature of Juneral Service Licenses 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home
26401 Ridge Road, Damascus, Maryland Hove 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hepato renal Physician/ Syndrome disease or condition Medical resulting in death) Examiner Cirrhosis Sequentially list conditions. Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav Pregnant at time of death 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown Records, Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 🗆 No this certificate Yes 2 No 1 Yes Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) 2 No Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٥ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director; After I 1 Natural work?
1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number October 18,240 D62180 treet Frederich erson who completed cause of death (Item 23a) (Type, Print) MD 400 West 7th 32. Registrar's Signature 31. Date filed (Month, Day, Year, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ (tober Douglas Anderson *5:39* Рм dolo Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Lanham Prince Georges Doctor's Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1**XX**M 2 □ F Months Days Hours 05-18-1920 90 242-16-7507 Director N.C. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If firem 27 is marked other than "natural", or items on any injury or other trainme 10b. County 10c. City, Town or Location **Washington** 10d. Inside City Limits Completed by Funeral Director 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20011 5719 5th Street NE USA 12. Was Decedent Ever in U.S. Armed Forces?
1 X Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black White etc. 1 X Never Married 2 Married Specify:Black 1 ☐ Yes XX No Specify: 3 🗌 Widowed 4 🗎 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Private Food Handler 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jones ဂ Mannie Douglas Anderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5719 5th Street NE Washington, DC 20011 19a. Informant's Name/Relationship (Type, Print) Graham Annie Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Nelson Chapel Cemetery 10-23-2010 1 X Burial 2 Cremation 3 Removal from State Louisburg, NC 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bianchi 814 Upshur St NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician neumor disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23h. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X N 2 No After this certificate 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 2 X No မှ 1 Yes 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27, Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury X Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital of within 24 hours a To the Funeral D Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature ar Name and address of person who ompleted dause of death (Item 23a) Type, Print) Luck Road Lanham Good Omolara 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Catherine Albrittain Eleanor Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical Plata a Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5 Social Security Number 7. Age (In vrs. last birthday **Funeral** Country) Maryland 1 🗆 M 2 🖵 F Months Hours April 10,1926 219-16-0984 84 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show 10a, State death with the Maryland injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 x No MD Charles La Plata 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 8870 King Edward Place 20646 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify. If Yes, Give "natural", 3 XWidowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) filed within 72 tal Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Supervisor/Accounting Federal Govt. Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) and Mental H ပ Catherine Natalee Radcliff Douglas Tilton Cooksey permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8870 King Edward Pl. La Plata,MD Mary Alice Good/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State St. Ignatius Cemetery 10/16/2010 Port Tobacco, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MO0945 AREHART-ECHOLS FUNERAL HOME, P.A. 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the model dying status as a rad Verespir by 11 a La, MD Approximate shock, or heart failure. List only one cause on Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition) Medical resulting in death) Due to or \$ consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-transit Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No sate has been signed by the atte page 2 should be detached for a Month Day Year Pregnant at time of death 5 Other (specify) q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ension 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed' 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate I 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred completed filled in by the funeral 28c. Injury at 1 X Natural iniurv work? 1 ☐ Yes 2 ☐ No 5 \square Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) enature and 29c. License number 10-13-2010 D0053219 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Waldorf, MD 20602

State

Registrar

OCT 15

				State								ental Hy		_		
1			for State Registrar					rtificate					Reg. No.	0 0 1 0	34550	
	Physicia	an	1. Decedent's Name (First, Mi PHYLLIS M		MS							2. Date of De Month OCT 2		010 Year	3. Time of Death 5:28A M	
-	/Medic Examin		4a. Facility Name (If not institu				4b. City, Town, or Location of Death			of Death		_	County of Death			
	Examin		WASHINGTO	N ADVENT	IST	HOS	SP.		A PA		PRINCE GEO			GEORGES		
	Funeral Director		5. Social Security Number 218-52-7746	6. Sex 1 □ M 2 🙀 F		e (In yrs. I	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 9 - 2 - 1	ate of Birth 9. Birth 1000th, Day, Year) MD		place (State or Foreign ntry)	
	D		Usual Residence of Decedent			40- 01	y, Town or Lo		1		1				10d. Inside City Limits	
	Maryla e-f shov	tor	MD. 10b. Cou	RLES		Toc. Oil	y, IOWITOT LO	WALDORF						1 ∐Yes 2 ∐ X No		
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It was a few 27 is marked other than "natural", or Items 23a or 286-f show other traumetic event, the Medical Examiner must be retified at	I Director	10e. Street and Number 1306 GREEN	GATE COU	RT			10f. Zip	Code 206	01			-	I0g. Citizen of What Country? U _▶ S _▶ A _▶		
	er death	Funeral	11. Marital Status		Forces?		S. 13.	Was Deced If Yes, spec	lent of Hi cify Cuba	spanic Ori n, Mexican	gin? (Spe	ecity Yes or No Rican, etc.)	/ Yes or No- an, etc.) 14. Race - American Ind Black, White, etc.			
0000	ours aft rral", or Lexami	þ	If Yes, Give 1 ☐ Yes 2 M No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates:									Specify: WHITE				
7	iin 72 h n "natu ledica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)								16b. Ki	6b. Kind of Business/Industry				
7 7	filed within Hygiene. other than '	Com	12th MEDICAL TRANSCRIPTIONIST SO.MD.HOS										PITAL			
land	uld be file Aental Hy rked oth tic event	To Be	17. Father's Name (First, Middle, Last) HAROLD TRIMPOWED								18. Mother's Name (First, Middle, Maiden Surname) MILDRED MARIE HAMNER					
lary	2 should I h and Men is marke raumetic		19a. Informant's Name/Relati		1			3					, ,	or Town, State, Zi		
D	s 1 and 2 f Health ftem 27 i		DONALD ADAM 20a. Method of Disposition			20b. P	lace of Dispo	GRE	ne of	ŧ	D	ate		RF,MD.		
Dallimor	Pagestment of tents of tents of jury or		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other			RINI	TY ME	EM.GA	RDE	NS 1				DORF,MI) .	
מ	permit. Pages 1 an Department of Heal Importent: If Item 2 eny Injury or other once.		21. Signature of Funeral Serv	ice Licensee M	004	79 —		RAYMO LA PL	nd Addres ND LATA	ss of Facilit FUNE MD.	RAL 206	SERVI	CE,	P.A.		
ine de la	Physician /Medical		23a. Part 1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	ist only one cause of	reach lin	ne. 10SC	n. Do not ent	er the mod	le of dyin	g, such as	cardiac c		rrest,		Approximate Interval Between Onset and Death	
	Examiner		Sequentially list conditions	b.	to (or as	a consequ	uence of):									
	uted d ansit	Examiner	Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or injury	quence of).												
,00,	be executed sician and burial-transit	cal Exa	that initiated events resulting in death) Last	Due	to (or as	a consequ	uence of):									
100	ificate g phys															
O. DOX	The law requires that the death certificate tate has been signed by the attending physic page 2 should be detached for use as the b	hysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 W No 9 □ Unknown		e birth egnant a	of pregna 2 ☐ Fetal t time of d	Ideath 3[∃Ectopic p ∃Other <i>(sp</i>		ý				23d. Date of deli Month	very Day Year	
ν, Γ	uires that the de signed by the a Id be detached f	by Ph	Part II. Other significant con-				-	nderlying c	ause give	en in Part I					the cause of death?	
Spics	requir been s should	eted	Chronic	Try (Fee	1/4	FR.						100000	Yes 2		obably 4 Unknown	
ב ב ב	t: The law icate has page 2 t	Completed	Comomic	LONG D	100	ate	•					24a. Was auto perfo 1 🗆 Yes	psy ormed?	prior to codeath?	opsy findings available ompletion of cause of 2 No	
\ \ \	sicien certifi irector	Be c	25. Was case referred to med examiner? 1 ☐ Yes 2 ☐ No	Hospital:	- Innetic	0 🗗	R/Outpatie	at 2 🗆 DC	Othe	or.		(Check only o		6 DOther (Coo	74.3	
5	ng Phy fter this neral d	on: To	27. Manner of Death	28a. Da	te of Inju	iry	28b. Time o		28c. Injury Work			28d. Describe		6 ☐ Other (Spec ry occurred	ny)	
018101	or Attendl ifter death. Olrector: A in by the fu	Certification:	2 Accident inve	estigation uld not be 28e. Pla	ice of Injui	ury - At ho c. <i>(Specif</i>	ome, farm, str y)	M eet, factory		Yes 2□		28f. Location (City or To	Street ar wn, State	nd Number or Rui e)	ral Route Number,	
_	To the Hospital or Attending Physicien: The law requir within 24 hours affer death. Of the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should	edical Ce		fying Physician: To cal Examiner: On the and m		f examina										
	To the within To the comp	Me	29b. Signature and title of cer		01	0)	290	c. Licenso	e number				ate signed (Month		
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul A. Devort MD 423 Queensbury Rd Hyattsville MD 20781								20/2						
			Paul A. De	Varie Mil	420	3 G	Welks	bery.	Rd	Hyaz	15011	Ve MI)20	781		
	Sta Registr		31. Date filed (Month, Day, Ye	V 0 4 2010	. Registr		ture .									
								-								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #23a&b Per PHY 6910-12/07/10 Lifeth and Montal Liveing

			For State Registrar	State of Mary		tificate of L			giene Reg. No 2010	34551		
	Physicia		1. Decedent's Name (First, Middle, Las Malvina	BU	JRSTEIN			2. Date of Dea Month October		3. Time of Death 10:55 PM		
	Medic Examin		4a. Facility Name (if not institution, give	street and number)		4b. City, Town, or Rockvi	Location of Death		4c. County of Death			
Hamber of the	Funeral	-	The Ring House 5. Social Security Number 6. Secu		rs. last birthday)	If Under 1 Year Months Days		8. Date of Birth	Montgomery 9. Birthplace (State or Foreign			
	Director		105-24-9584 Usual Residence of Decedent	97	Yrs.			April 17	7, 1913 Czec	EMoslovakia		
	aryland a-f shov fied at	Director	10a. State 10b. County MD Montgome		. City, Town or Loc Rockville					10d. Inside City Limits 1 ☑ Yes 2 ☐ No		
	a or 28 be noti	al Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of What Cou			
	ems 23 r must	Funeral	1801 East Jeffe	12. Was Decedent Ever in	U.S. 13. V	20852 Vas Decedent of H	spanic Origin? (Sp	ecify Yes or No-	U.S.A.	14. Race - American Indian,		
036	s after de ral", or it Examine	Completed by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 【 No If Yes, Give Year or Dates.		If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🌠 No Specify:			Black, White Specify:	, etc. White		
15-0	72 hour n "natu Aedical	nplet	15. Decedent's Ed (Specify only highest gra	de completed)	(Give I	lent's Usual Occup kind of work done o O NOT use retired)	ation during most of work	king	16b. Kind of Business li	ndustry		
212	ygiene. her tha	0	Elementary/Seconday (0-12)	College (1-4 or 5+)		maker			Millinery			
land	l be filed fental H rked ot tic ever	To B	17. Father's Name (First, Middle, Last) Solomon	Grunfeld			18. Mother's Nam	Name (First, Middle, Maiden Surname) Freider				
Mary	12 should alth and M 27 is ma r trauma'		19a. Informant's Name/Relationship (Type, Print) Miriam Burstein /daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 209)									
more,	age 1 and ent of Hez nt: If item ry or othe		20a. Method of Disposition 1 ⚠ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	20c. Location - City or T Adelphi, Md								
雪	The purpose of the pu											
			23a. Part . Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	olications that caused the cause on each line.	death. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death		
	Physician/ Medical Examiner		disease or condition resulting in death)	a. Due to (or as a cons	sequence of):	hagia Failure t						
	- = = = = = = = = = = = = = = = = = = =	iner	Sequentially list conditions,	b. Due to (or as a cons	sequence of:							
	icate be executed ip physician and is the burial-transit	dical Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a cons								
200	cate be physici the bu			d								
P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 Live Birth 2 L 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnand Other (specify)	ey		23d. Date of deli Month	very Day Year		
, P.O.	es that the igned by be detacl	by Ph	Part II. Other significant conditions of Diabetes Mellit	_	t resulting in the u	inderlying cause giv	ven in Part I.		bacco use contribute to			
ords	v require s been s s should	Completed by	Diabetes sierrie					24a. Was a	n 24b. Were aut	opsy findings available ompletion of cause of		
Rec	: The lay cate has							autop perfor 1 \(\sum \) Yes	med? death? 2 No 1 ☐ Yes	2 No		
Vital	ysician is certifi director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	2 ☐ ER/Outpatier	Oth	ace of Death (Chece er: 4 \sum Nursing H		ence 6 🔯 Other (Speci	ssisted		
n of	nding Ph th. : After thi e funeral		27. Manner of Death 1 ↑ Natural 5 □ Pending 2 □ Accident Investigation	28a. Date of injury (Month, Day, Yea	28b. Time of injury	work	y at		ow injury occurred			
Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	Certificate:	3 Suicide 6 Could not b 4 Homicide determined			eet, factory, office			n (Street and Number or Rural Route Number, Town, State)			
_	ne Hospitt n 24 hours ne Funera pleted fille	Medical	(Check 2 Medical Exami	sician: To the best of my kiner: On the basis of examing Practioner: To the best of	ation and/or invest	tigation, in my opinio	on, death occurred a	at the time, date ar	nd place, and due to the c	ause(s) and manner stated.		
	To within		29b. Signature and title of certifier	1	~	29c. License D3557		- 1	29d. Date signed (Month October 19			
			30. Name and address of person who consume Susan J. Miller	ompleted cause of death ((Item 23a) (Type, F Wisconsi	n Ave.#30)5, Bethe	sda, Md.	20814			
Ī	Sta Registr		Od Data Stad (Manth Day Voor)	32 Registrar's Si								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State o	of Marylar		artment <i>tificate</i>			and M	•	_	211	0	34	552
			Registrar 1. Decedent's Name (First,	, Middle, Last)			Oei	incate	010	Gatti		2. Date of Dea	Reg. No ath	0.		3. Time o	
	Physicia Medic			Janet K	. Buns	gav						Oct.	$\overset{Da}{1}$	4 2	Year 2010	6:25	A M
	Examin		4a. Facility Name (if not ins					4b. City, To	own, or l	Location o	of Death		40	. County o			
	<u>/</u>		Suburban					Bethesda						Monte	gomer	У	
	Funeral		5. Social Security Number]м 2 🖾 F	7. Age (In yrs. I		If Under 1 Months	Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Date Oct. 3	th y, Year)	0,0	9. Birthp Count Mary	lace (State	or Foreign
	Director		218-40-098 Usual Residence of Deced				67 Yrs.					0ct. 3	1 1	942]	Mary	land	
	and show	ō	10a. State 10b. 0	County		10c. Cit	y, Town or Loc	ation							10	Od. Inside C	City Limits
	Maryl 28a-f otifiec	rec	MD Mo	ontgome	ry	Ве	thesda									1 🗌 Ye	s 2 🔼 No
	a or 2	I Di	10e. Street and Number			•		10f. Zip (Code				10g. Ci	itizen of WI	hat Count	try?	
	h with	Funeral Director	5110 Batte					208					Un	ited	Stat	:es	
	r iten iner		11. Marital Status		Armed Fo		S. 13. V	Vas Decede Yes, specif	nt of His y Cuban	panic Orig , Mexican	gin? (Spe , Puerto l	cify Yes or No- Rican, etc.)		14. Race Black	- America , White, e		
336	al", o	d b	1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Di		1 Tes If Yes, Giv Year or Da	re	1	☐ Yes 2	₩ No	Specify:				Specify:	Whi	te	
21215-0036	hours natur lical 1	Completed by		Decedent's Edu	cation		16a. Deced	ent's Usual	Occupat	tion			16b. k	(ind of Bus	iness Ind	ustry	
215	iln 72 ie. han " Mec	E	Elementary/Seconday (ly highest grad (0-12)	College (1		(Give k life. DC	ind of work NOT use r	done du etired)	iring most	of workir	ng		nterna			
2	d with ygien her tl nt, th	Be C				4	Edi	tor	-					netary	y Fur	ıd	
and	ntal H ed ot	To B	17. Father's Name (First, M									(First, Middle,	Maiden	Surname)			
Ĕ	ould b d Mer mark matic		M. Warner 19a. Informant's Name/Re		o Drint)		10. 14. 11					ylor	0	- a	. 7: 0		
¥a	2 sho Ith an 27 is		Peter M. B			e		-				Route Number	-			oae)	
Baltimore, Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition)		20b. F	Place of Dispos	sition (Name	of	- 1		ate		ocation - C		wn, State	
m 0	Page nent o nt: If		1 ☐ Burial 2 🖾 Crei 4 ☐ Donation 5 ☐ 0		Removal from	Clate	Tinco	-			0/20	/2010	Bre	ntwoo	od. M	(arv1a	and
alti	permit. F Departm Importa any inju		21. Signature of Juneral Se		-	M0146		Name and				mple Ti			, i	idi y ic	
<u>m</u>	8 8 E 8		LUSCH				10)40 Rc	ckv:	ille		, Rock			208	352	
			23a. Part 1. Fin er the dise shock, or neart failure	ease, or compli- e. List only one	cations that of cause on ea	caused the deat ich line.	h. Do not ente	r the mode	of dying,	, such as o	cardiac o	respiratory arr	rest,			Approxima Interval Be	
SI	Physician/	- 10	Immediate (lise (Final disease or condition	a		CVA										Onset and	Death
4	Medical Examiner		resulting in death)			(or as a consequ											
7		e.	Sequentially list conditions	s, b		ercoagu or as a consequ		state							_		
36	dust ted	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	*	Bueto	(0) 40 4 00 1100 41	201100 01/1								- 1		
0	s be executed sician and burial-trasit	Ĕ	that initiated events resulting in death) Last		Due to ((or as a consequ	uence of):										
۵ <u>.</u> 9	that the death certificate be executed ned by the attending physician and etached for use as the burial-trinsit	dical		C d											\perp		
2.0	eath certifical attending ph I for use as th	Me	IF FEMALE:														
-	th cel ttendi or use	ian/	23b. Was decedent pregna in the past 12 months	ai i i	1 Live	come of pregna Birth 2 Feta	al death 3 🗌	Ectopic pre	egnancy					23d. Date Mont		•	Year
[14] Boy	the a	Physician/Me	1 ☐ Yes 2 🔀 No 9 ☐ Unknown		9 Unkr	nant at time of one	death 5 ∟	Other (spec	ciry)					1110110		, 	104
0 O	ires that the des signed by the a id be detached f		Part II. Other significant o	onditions con	tributing to d	eath but not res	ulting in the ur	nderlying ca	use give	n in Part I.		23e. Did to	bacco i	use contrib	oute to the	e cause of o	death?
	uires t n sign uld be	Completed by										1 🗆 '	Yes 2	□ No 3	Prob	ably 4 🛚	Unknown
Records,	Physician: The law requires this certificate has been sign ral director, page 2 should be	plet										24a. Was		24b. We	ere autop	sy findings	available
avert	sician; The law certificate has b irector, page 2 s	mo;	· · · · · · · · · · · · · · · · · · ·										rmed? 2 x N	de	eath?		cause of
SEV.	ian; ertifica ctor, p	Be (25. Was case referred to m examiner?						26. Plac	ce of Deat	h (Check	-1					
المحرا	hysic this ce	은	1 ☐ Yes 2 🔀 No	H	_	Inpatient 2				4 ∟ Nu		ne 5 🗆 Resid					
20	ding Phy th. After this funeral d	ate		Pending	28a. Date (Mont	of injury th, Day, Year)	28b. Time of injury		c. Injury a	at	- 1	8d. Describe h	ow injur	y occurred	I		
\$.io	l or Attending after death. Director: After I in by the fune	Certificate:	3 🔲 Suicide 6 🗌	Investigation Could not be	28e. Place	of Injury - At ho	me farm stre	M et. factory.	_	es 2 □		8f. Location (S	troot an	nd Number	or Rural i	Route Num	her
Š).\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	al or A safter I Direc d in by	Sel	4 Homicide	determined		ng, etc. (Specify		01, 1401019,			ľ	City or Tow			or marari	loute Hulli	Der,
Biringay Divisio	To the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical				est of my know											
CCF	the H thin 24 the Fi	Me	only one) 3 🗆 Cer	rtifying Nurse		is of examination To the best of m		eath occurre	ed at the	time, date	and place	e, and due to the					anner stated.
*_	To the within 2		29b. Signature and title of	certifier	51	MO		29c. l	icense r	66	26	9		te signed (
	1-1		00.1		ノ <u> </u>		- 00-) 77 =					,	•	41	///		
			30. Name and address of p Babak S. I						wn R	d. B	ethe	sda, MD	208	814			
	Stat	e										,					
	Registra	ar	OCT	2 U 2010	1 Dex	egistrar's Signa	1. 100	Kind									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ :50p Gladys M. Breedlove 10 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Oakland Nursing & Rehabilition Center 0akland Garrett 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) Months Hours Min. 1 M 2 X Director 217-18-4990 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b Count 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 X Yes 2 No Garrett 0akland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Completed by Funeral 706 E. Alder Street 21550 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No 3 ₩ Widowed 4 □ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Farmer Farming Be be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) d Mental I ဂ္ Edna M. Shafer Lemial E. Beckman and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health item 27 i Marilyn Bietzel-daughter in 1<u>aw</u> Accident MD 21520 1762 Accident Friendsville Rd 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or o I 🗌 Burial 2 💢 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) Cumberland Crematory 10/28/2010 Cumberland, MD Signature Funeral Service Licenses 22. Name and Address of Facility David A. Burdock Funeral Home P.A 2nd Street, Oakland, MD 21550 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Erebrovascu cider Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): rsician and burial-transit Cause (Disease or iiniury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician ched for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death be detached 9 Unknown g 🗌 Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying çause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy death? 2 🗌 No 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 - No ဥ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral (28b. Time of To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 21550 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Buc 2925/5 und State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dorothy Lee Blank Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Western Maryland Regional Medical Center Cumberland Allegany 8. Date of Birth (Month, Day, Year) March 20, 1923 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland **Funeral** 1 🗆 M 2 🛣 Days Hours Min Director 215-12-2511 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits filed within 72 hours after death with the Maryland Director be notified Maryland 1 X Yes 2 No Allegany Frostburg 5 10e, Street and Number 10f, Zip Code 10g Citizen of What Country? items 23a Funeral 48 Tarn Terrace 21532 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc or . by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", Completed 3 Widowed 4 Divorced Specify. White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry ould be more and Mental Hygiene.
s marked other than "r (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 0 Housekeeper College permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Thomas Francis Nicol Mamie Rosetta Grove 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11103 Welsh Hill Road S.W., Frostburg, Maryland, 21532 Jacqueline Kerr - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date October 25 ☐ Burial 2. Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory Cumberland, Maryland 2010 Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Myocardia adays disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Securetistly flet expellions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Advanced 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 X No ဂ္ X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier woreockshir MD 00055325

DHMH 17 Rev 7/2009

State Registrar 925

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)-(Type, Print)

WONSOCK

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	_ State	•	ertificate of Death	and Men		0010		
i			Registrar 1. Decedent's Name (First, Middle, Last)		minoute of Beati.		Reg. Date of Death	2010	3. Time of Death	
	Physicia Medic	al	Bettie Lou Tay	or Buckla			ctober	^D 21, 2010		
	Examin	er	4a. Facility Name (if not institution, give street and number) 88 Bard Cameron Road		4b. City, Town, or Location Rising St			4c. County of Death Cecil		
	Funeral Director		5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday) 81 Yrs.	If Under 1 Year If Under Months Days Hours	Min. F6	Date of Birth (Month, Pay Yea e b 3,	⁷ 1 929 9. Birti	hplace (State or Foreign untry) Ohio	
	and show 1 at	or	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits	
	Maryl. 28a-f otified	irec	Maryland Cecil	<u> </u>	Rising S	Sun			1 Yes 2 No	
	with the s 23a or ust be r	Funeral Director	10e. Street and Number 88 Bard Cameron Road		10f. Zip Code 2191	1	10g.	Citizen of What Co		
0-00-c	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent farmed Forces? 1 Yes 2 If Yes, Give Year or Dates.	Yes or No- in, etc.)	14. Race - American Indian, Black, White, etc. Specify: White					
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yland	be filed ental Hy rked oth ic event	To Be	17. Father's Name (First, Middle, Last) James Edward Taylo	en Surname) Marshall						
Mary	d 2 should alth and M 127 is mai r traumat		19a. Informant's Name/Relationship (Type, Print) Bryan Buckland (son)	19b. Mai	iling Address (Street and Numb Elk Forest Ro	ute Number, City Kton, M	or Town, State, Zic aryland 2	1921		
balulmore,	Page 1 and ment of He lant: If item ury or other		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		position (Name of ematory or other place) nk Cemetery	Location - City or sing Sun	Town, State , Maryland			
פון	permit. Depart Import any Inj		21. Signature of Funeral Service Licensee	an, Sc li	22. Name and Address of Facil Lee A. Patters Perryvil	ön & So le, Mar	on Funer cyland 2	al Home 1903-0766	P.A.	
	Physician / Medical Examiner the powerland	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	a consequence of):	nter the mode of dying, such as	s cardiac or res	spiratory arrest,		Approximate Interval Between Onset and Death	
. BOX 00/0	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Med		2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of de Month	livery Day Year	
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VITAI K	sician: certific rector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Input		26. Place of De		, , , , , , , , , , , , , , , , , , ,	e 6 🗆 Other (Spec	Si6.4)	
0 0	ig Phys ter this neral di	te: To	27. Manner of Death 1 Selection 1 Inpat 28a. Date of injute (Month, Death (Month, Death (Month), Death (Month	tient 2 ER/Outpati ury 28b. Time ay, Year) injury	of 28c. Injury at		. Describe how is		y)	
DIVISION	• Attendir er death. •ector; Af by the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury	jury - At home, farm, s	M 1 Tyes 2 Street, factory, office		Location (Street	t and Number or Ru	ral Route Number,	
2	spital or nours aft neral Di		29a Certifier 1 Certifying Physician: To the hest o	f my knowledge, death	h occured at the time, date and	d place, and du	ue to the cause(s	s) and manner as sta	ated.	
	the Ho thin 24 h the Fur	Medical	(Check 2 Medical Examiner: On the basis of only one) 3 Certifying Nurse Practioner: To the	examination and/or inverse best of my knowledge	estigation, in my opinion, death one, death occurred at the time, day 29c. License number	ate and place, a	nd due to the cau	lace, and due to the ise(s) and manner as Date signed (Monto	stated.	
	₽ ≥ ₽ 8		Co A.A.	. Phisic.	D5633		230.	\ \	0) 0	
	2		30. Name and address of person who completed cause of		, Print)	· · · · · · · · · · · · · · · · · · ·				
	Sta	te	31. Date filed (Month, Day, Year) 32. Registr	sナけられ S rar's Signature	St Ste 314	EIKhan	(W)	21921		
	Registra		OCT 2.2 2010 August	A. par	w					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death $1\overset{\text{Day}}{3}$, Physician/ 12:00P M October 2010 Joseph Freolia Brown, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Northhampton Manor If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) ug. 27, 1920 Days 1 🕱 M 2 🗆 F Months Hours Min. Country) MD Director 90 220-10-4701 Usual Residence of Decedent should be filed within 12 mount and Mental Hygiene.
and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 X Yes 2 No Myersville MD Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21773 109 Main Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married 2 1x Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify Completed 3 Widowed 4 Divorced White Year or Dates. 1942-1945 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) land surveyor other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ျ Ann Angela Byrnes Joseph Freolia Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 46, Myersville, MD 21773 19a. Informant's Name/Relationship (Type, Print) 1 and 2 s f Health item 27 Anna Lee Brown-wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or otl 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Oct.15,2010 Frederick, MD Stauffer Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallere. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ umania disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** ilzheim Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Month Day 4 Pregnant at time of death 9 Unknown 1 Yes 2 No 9 Unknown the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 this certificate has autopsy performed' 1 ☐ Yes 2 ☐ No Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 2. No Other: 1 Yes Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ဂ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours atter usau...
To the Funeral Director: After th Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Lacertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number DO 9689 Parre 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Austin Pearre 300 W. 9th St., Frederick, MD 21701-4541 OFIVE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OC. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State Amend Item 25 per me,	laryland / Der g912,02/25	partment of F 5/2011dhb ertificate of L	lealth and N Death	1ental Hygi Re	ene eg. No. 2 A A	31.557				
	Physicia		1. Decedent's Name (First, Middle, Last) Helen Louise Benn	a++			2. Date of Death Month October	Day Year	3. Time of Death				
	Medic Examir		4a. Facility Name (if not institution, give street and number)			Location of Death	OCTOBER	16 2010 4c. County of Dea					
	Formand	P	Johns Hopkins Bayview M. 5. Social Security Number 6. Sex 7. A	edical Center		If Under 24 Hrs.	8. Date of Birth	L O Bi	Abulaa (Obida a Fauria)				
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	or 28a- notifie	Director	Maryland Frederick 10e. Street and Number	Ijamsvi	10f. Zip Code		146	O Cities of Miles of O	1 ☐ Yes 2 🖰 No				
	s 23a c	Funeral	3704 Lawson Road		2175	4		ng. Citizen of What Co USA	ountry?				
920	ould be filed within 72 hours after death with the Maryland Mental Hygiene. In Mental Hygiene. Marked other than "natural", or items 23a or 28a-f show marked other than "natural" or items 25a notified at matic event, the Medical Examiner must be notified at	δ	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Armed Forces 1 □ Yes 2 ☑ If Yes, Give Year or Dates.	Ever in U.S. 13	3. Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 🎦 No	n, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: white					
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land	l be filed lental Hy rked oth	To Be	17. Father's Name (First, Middle, Last) Floyd E. Miller			18. Mother's Name Kathry	(First, Middle, Ma n Cogan	aiden Surname)					
	Shhar har 7 is trau		19a. Informant's Name/Relationship (Type, Frint) Donald R. Bennett, Sr - hu	1 11	illing Address (Street a				o Code) 21754				
Baltimore,	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other i		20a. Method of Disposition 1 ★ Surial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place of Disposemetery, cree	position (Name of ematory or other place Union Cen)	I	Oc. Location - City or	Town, State				
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	Ì		30. Name and address of person who completed cause of d	leath (Item 23a) (Type	T5	145	10	ctober 10	0, 2010				
	10		COURTNEY RORY GOODWIN	M.D. 49	40 EAST	ERN AVE	NUE BA	ALTIMORE,	MD 21224				
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Physici		Maude D.	Burke							Octobe	Da	7 20Ĭ8	10	:35A M
/Medio		4a. Facility Name (If not institution Friends Nur	sing Home			4b.			tion of Death		4c.	County of De	eath gomery	
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Imp Degrand	21. Signature of Funeral Service Licenses 22. Name and Address of Facility Muriel H. Barber Funeral Home P. 0. Box 5038, Laytonsville, Md												. 2088	2
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uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	or as a co	insequence of	n): 4 G	Dy	CEC	CT	1621			Ive	2443
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ificate by physicas the bi	edica	Co. SEHILE DEMENTIA										Yei	3125	
th certition that the second in the second i	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou		regnancy Fetal death	3□Ector	pic pregnar	ıcv				23d. Date of		V
law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	by Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		nant at tim	e of death		er (specify)					Month	Day	Year
es that gned k	by PI	Part II. Other significant condition	ons contributing to d	eath but n	ot resulting in	the underly	ing cause	given in P	art I.			use contribute		
requir										1 🗆			Probably 4	
The law ate has I page 2 s	Completed									24a. Was auto perfo 1∐ Yes		death	autopsy findin o completion o ? es 2 □ No	gs available of cause of
sician: certific rector,	Be	25. Was case referred to medical examiner?	Hoenital:					thor:		n (Check only				
g Physer this eral di	n: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date	•	2 ER/Outp	me of	DOA 28c. In	408		me 5 Resi 28d. Describe			pecify)	
ending eath. or; Aft the fun	atio	Matural 5 ☐ Pendin 2 ☐ Accident investig	gation			jury M	1	Yes	2□No					
al or Att s after de al Direct ed in by t	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 28e. Place build	e of injury ling, etc. (S	At home, fari Specify)	n, street, fa	actory, offic	е		28f. Location (City or To	Street ar wn, State	nd Number or e)	Rural Route N	lumber,
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur	Medical (29a. Certifier (Check only one) Certifyin 2 Medical	g Physician : To the Examiner: On the band man	asis of ex	amination and	or investig	ation, in m	y opinion	, death occur	red at the time	cause(s , date an) and manner d place, and c	as stated. lue to the caus	se(s)
To the Vithin To the Comp	Me	29b. Signature and title of certifier	0.1.0				29c. Lice	nse numb	ber		29d. Da	te signed (Mo	nth, Day, Yea	r)
		John 2	Dlan	دريم	3		D	: کد	34>		101	17/10	21/12	
7		30. Name and address of person	who completed caus	se of death	(Item 23a) (7 3 3 3 Signature	ype, Print) Ω\⊂C	25 CI	MAN	ex Rd	SIL	1613	PHD	2000	5
Sta		31. Date filed (Month, Day, Year)	1 2 20 32.	Registrar's	Signature	1 L	Pr. Elas	13(-		401141	~1 ~	13.1.0	4010	
Registi	ar	UUI	TO 2010	Jude with	port for	1 11	S. S. C.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ :10 HAROLD BOZMAN 2010 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town or Location of Death **Examiner** 105 0 m 24 Hrs. 8. Date of Birth (Month, Day, Year) 01–23–1921 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Months Min. 220-32-0592 89 MD. Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 Yes 2 No Md. Somerset Fairmount 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral U.S. 27645 Fairmount Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: white If Yes, Give Year or Dates Completed 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Seafood Business 1st.--6th. Owner-Operater Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Flona Willing Bozman Clinton Bozman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30436 Plantation Dr. Princess Anne, Md. 21853 Daughter Shirley Barry 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Wicomico Memorial 1 Burial 2 Cremation 3 Removal from State 10-16-2010 Salisbury, Md. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility HINMAN FUNERAL HOME M00295 11673 Somerset Ave. Princess Anne 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ZMBN TIA Physician/ disease or condition / Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying the attending physician and hed for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No page 2 should be detached for Month 5 Other (specify) 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has death? 1 Yes 2 No this certificate To the Hospital or Attending Physician: "
within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, to 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence မှ 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certificate: Natural 5 Pending Accident Investigation Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated United Descripting Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Year Physician/ October 8, Dana Collins Belser, Jr. 11:30 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bethesda Montgomery Suburban <u>Hospital</u> 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1 **X** M 2 □ F Sept. 18, 1926 721-10-8138 Hours Georgia Director 84 Usual Residence of Decedent shov 10a. State 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner <u>must be notified at</u> Director 1 X Yes 2 No MD Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 8101 Connecticut Ave., #607N 20815 U.S.A 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 □ No WOY If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 2 No World Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify. 3 Widowed 4 Divorced Year or Dates. War II White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Business Owner Promotional Products Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Caroline Gartrell Blount Dana Collins Belser t, Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8101 Conn.Ave.#607N,Chevy Chase, MD 20815 <u>Patricia Reed Belser/Wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date permit, Page 1 a
Department of H
Important: If ite
any injury or ot October 2010 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, Virginia Signatury of Funer VS yee License 22. Name and Address of Facility DeVol Funeral Home MO1315 10 East Deer Park Drive Gaithersburg, Md 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cardiorespiratory arrest disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Intracerebral Hemorrhage Sequentially list conditions, Due to for as a consequence of ng physician and e as the burial-transit cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 K No 1 ☐ Yes 2 ☐ No **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ၉ 1 🖾 Inpatient 2 🗆 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 🔲 Yes ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours af

To the Funeral Di

completed filled in Medical 29a. Certifier 1 🖸 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif MU

Registrar

DHMH 17 Rev 7/2009

State

2330

01180

VZ

Shanthi Nadar, MD 2150 Pennsylvania Ave., NW Suite 5-411 Washington, D.C. 20037

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

OCT 1 4 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For AMEND#23a, 23e, 24a/6, 25, 26, 27, 29aperMD10/19/10, BMW, MoCo Registrar Certificate of Death Reg. No. Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Oct. Physician/ 201 0 William 10:43PM Frank Ballard Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 23 Donovan Court Frederick Brunswick Social Security Number Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth g. Birthplace (State or Foreign Days 1 XM 2 F Months Hours Min. DC Country) Director 56 578-72-1606 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location injury or other traumatic event, the Medical Ex. miner must be notified at 10d. Inside City Limits Director 1 Yes 2 □ No MD Frederick Brunswick ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a by Funeral 23 Donovan Court 21758 USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Manital Status 14. Race - American Indian, Hygiene. other than "natural", or i Black. White, etc. 1 Never Married 2 Married Agitimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes Give 3 Widowed 4 Divorced Specify: Black Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Years Federal GOvt. permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other? Maintenance Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Frank W. Ballard Doris Fairfax 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Prunswick, MD 21758 19a. Informant's Name/Relationship (Type, Print) Diane V. Ballard/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Removal from State Ft. Lincoln 4 ☐ Donation 5 ☐ Other (Specify) Brentwood.MD 10/16/10 22. Name and Address of Facility Latney's Funeral Home, Signature of Funeral Service Licensee Inc. 3831 Georgia Ave. NW Washington, DC 20011 cc02781 23a. Part VEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Esophugus Immediate Cause (Final 18 months d Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): burial-1 physician at the burial-Physician/Medical P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Pregnant at time of death Day Year Ś signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2X No 1 🗌 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific gempleted filled in by the funeral director, 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) 2X No ဂ္ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 \(\sup \text{No} 2 Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) 8503 a 30. Name and address of person who completed cause of death (Nem/23a) (Type, Print) WON Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle 2. Date of Death Physician/ Medical Name (if not institution, g County of Death Examiner If Under 24 8. Date of Birth (Month, Day, Sept. I 9. Birtho Funeral 1 X M 2 D Months Days Hours Min. Country) Kentucky 67 407-60-0540 Director Usual Residence of Decedent 28a-f shov 10b. County 10a. State with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7575 East Howard Road 21060 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc þ 1 Never Married 2 Married African 1 Yes 2 No Specify. 3 Widowed 4 X Divorced "natural" Completed American the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 | Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other thany injury or other traumatic event, the once. Attorney Self-Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Grandison Blakev Lorraine Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 401 621 Admiral Drive # 207 Jeraldine Kayanaugh - Guardian Annapolis, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State October 19 Lee's Crematory 4 Donation 5 Other (Specify) Clinton, Maryland 21. Sid ature of Funeral Service Licens 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC 23a. Part . Enter the disease, or complications the shock, or heart failure. List only one cause on or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any adding a majoral cause. Enter Underlying Cause (Disease or iinjury Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year by the Unknown 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? 6 1 Yes 2 No 3 Probably 4 Unknown Be Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 2 No 1 Yes 26. Place of Death (Check only one) examiner? 101 2 X No 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, this eral Director: After th filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Division of Vital Records, P.O. Box 68760 hours after within 24 hours a

To the Funeral C

> State Registrar

only one) 29b. Signature

OCT 2 0

on who completed cause of death (Item 23a) (Type, Print)

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Month / 3. Time of Death Physician/ 0750 AM Clifton F. Brimer Medical 4a. Facility Name (if not institution, give street and number 4c, County of Death Examiner spice at the L Isbury NICOMICO If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Hours Mary Land Director 51 Yrs Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director or 28a-f st notified 1 X Yes 2 No MD Pocomoke City Worcester 10e. Street and Number 10f. Zip Code 5 10a, Citizen of What Country? ral", or items 23a o Examiner must be Funeral USA 24 Greenway Avenue 21851 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc 1 Never Married 2 Married ģ 1 Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: white marked other than "natural", 3 XWidowed 4 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Estimator Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Clifton Paul Brimer Alice R. Vessey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Vessey (Mother) 24 Greenway Ave., Pocomoke City, MD 21851 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) First Baptist Cemetery 10/20/2010 Pocomoke City, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Home, Professional Association 107 Vine St., Pocomoke City, MD 21851 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician/ CIMPIHOSIS -1 VR12) Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 Yes 2 No Day Month Year ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1000 1000 28a. Date of injury (Month, Day, Year) Certificate: Mapmer of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Partifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and the of certifier D00 58410

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Registrar

31. Date filed (Month, Day, Year)

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and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Marvin William Burkman 16, 2010 October 7:08 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert. Calvert Memorial Hospital Prince Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Min. 1X M 2□ F Hours 64 217-46-6565 09-09-1946 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ed other than "natural", or items 23a or 28a-f shove event, the Position Examiliar must be confirmed at MD Calvert Lusby 1 ☐Yes 2X No Director within 72 hours after death with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 10375 H. G. Trueman Road 20657 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Vietnam 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 7 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Heavy Equipment Operator Excavation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) I and 2 should be fill Health and Mental H Be Mildred Ethel Stinnett Henry Leroy Burkman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 10375 H. G. Trueman Road, Lusby, Maryland 20657 Jeanine Burkman / Wife tem 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 permit. Pages Department of Important: If its any Injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 10/17/10 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licenses P. O. Box 600, Lusby, Maryland 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to o as a consequence of) Examiner Spa roman Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No P.0. the detached 9 Unknown 9 Unknown signed by t Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ Yes 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a, Was an page 2 autopsy performed? Yes 2 No certificate 1 🗆 Yes Division of Vital e Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes (3/5)No 1 ☐ Inpatient 2 ☐ EB/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) within 24 and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

drw 12+1

State Registrar 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 24a&25 per med cert G910 12/17/10 lik

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 🤈 2. Date of Death 3. Time of Death I. Decedent's Name (First, Middle, Last) Year Oct 15, 2010 Physician/ 12:40 P Sylvia Czepiel Beatson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Marlboro Prince George's 7813 Locris Court If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 22. Social Security Numbe Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2**X**X F Hours 88 048 10 6846 Conn. Director Aug Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ıral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 XXNo Maryland 1 PrinceGeorge's Upper Marlboro 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20772 7813 Locris Court United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Black, White, etc. Armed Force 1 Never Married 2XX Married Yes 2 XXNo "natural", or ð Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: White Completed 3 Divorced 4 Divorced Year or Dates. is marked other than "natur aumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Health Care Registered Nurse Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Agnes Golet Vincent Czepiel 27 is marked 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7813 Locris Court, Upper Marlboro, MD 20772 Robert J. Beatson (Spouse) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cheltenham, Maryland 4 Donation 5 Other (Specify) Maryland Veterans Cemetery Oct 21, 2010 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 21. Signature of Funeral Service Lic Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Die to (or as a consequence of): Physician/ disease or condition Hyponotremia Medical Examiner resulting in death) Mycobacteri Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that in tisted expenses.) Examiner Due to (or as a consequence of): Browniechasis attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Que to (or as a consequence of): Physician/Medical Imonani P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) Pregnant at time of death been signed by the a should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Records, 1 Tes Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy performed: 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 XXResidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ြု 1 ☐ Yes 2 X No hin 24 hours after death.

the Funeral Director: After this or mpleted filled in by the funeral dii Manner of Death

Natural

Accident 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Registrar's Signature

Registrar
DHMH 17 Rev 7/2009

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TOWSON,

MARYLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BENNETT.

M.D.

32. Registrar's Signature

MARILYN H.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Helen COHEN Physician/ october 18, 2010 11:07 A.M. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Hebrew Home of Greater Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral June 5. 1 🗆 M 2 🖵 F New York Director 082-03-7260 ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery N. Potomac 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20878 U.S.A. 12302 Chagall Drive 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 N No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify should be filed within 72 hours after and Mental Hygiene. is marked other than "natural", 3 🔀 Widowed 4 🗆 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Brezinsky Sarah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9 Lily Pond Ct., Rockville, Md. 20852 Walter Cohen / son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1) Burial 2 Cremation 3 Removal from State 4 Donation 5 Ofther (Specify) King David Mem. Garden Oct.20,2010 Falls Church, VA 21. Signature of Mineral Service Licens 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carroll St., N.W., Washington, D.C. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only of e cause on each line. Onset and Death Immediate Cause (Final Physician/ Dementia. End disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Jus to (or as a consequence or). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and Il-transit Due to (or as a consequence of) resulting in death) Last physician a s the burial-Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Dav Pregnant at time of death 1 Yes 2 Unknown g 🗍 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No has 1 ☐ Yes 2 ☐ No Division of Vital • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certificieted filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 2 X No 1 🗌 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Naturai 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Fune completed fi Definition of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2

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31. Date filed (Month

29b. Signature and title of certifier

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Fazli

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

29c. License number

D0064871

10-18-10

Rockville, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34568 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 Wilbert Franklin Clark October 4:06a Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Dove House Hospice Westminster Carrol1 Social Security Number 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, 1 ⊠ M 2 □ F Months Hours Min Country) Maryland 75 **Director** 218-30-0393 934 Nov. Usual Residence of Decedent 28a-f shov 10a. State 10b. County traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 🔲 Yes 2 🔯 No Maryland Carrol1 Mt. Airy 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 23a Funeral 5241 Buffalo Road 21771 United States items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, rmed Forces?

Yes 2 \(\subseteq \) No Black, White, etc. ō ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1953-58 1 ☐ Yes 2 No Specify. "natural", 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Operating Engineer Soda Bottling Plant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edward Franklin Clark Florence Smallwood permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Buffalo Road, Mt. Airy, Maryland 21771 Charlene M. Clark / Wife 5241 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory Inc. 10/21/10 Frederick, Maryland 21. Signature of Juneral Service Licen Name and Address of Facility
Lauffer Funeral Homes P. A.
621 Opossumtown Pike, Frederick, Maryland21702 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Betwe Immediate Cause (Final disease or condition set and De Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) physician Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death certificate bewithin 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burnableted filled in by the funeral director, page 2 should be detached for use as the burnableted filled in by the funeral director, page 2 should be detached for use as the burnableted filled in by the funeral director, page 2 should be detached for use as the burnableted filled in by the funeral director, page 2 should be detached for use as the burnableted filled in by the funeral director, page 2 should be detached for use as the burnableted filled in by the funeral director, page 2 should be detached for use as the burnableted filled in by the funeral director. P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Year Dav Pregnant at time of death Yes 4 ☐ Pregnant a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown Disege 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed prior to completic death? 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Hospital: Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the be 29a. Certifier of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis f examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. he best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Certifying Nurse Practioner: To 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

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30. Name and address of person who

Yousuf Abdul

31. Date filed (Month, Day 19

555 South Center Street, Westminster, MD 21157

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

affar MD,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 34569 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Shirley Ann Newman Williams Clark October 2010 5:45A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Glade Valley Nursing Home Walkersville Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Sept. 26, **Funeral** Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 DM 2 X Hours 74 Country) West Sept. Director <u>577-52-6925</u> 1936 Virginia Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1X Yes 2 No Maryland | Frederick Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 105 Sandstone Drive - Apt. 112 21793 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 **X** No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Ь þ 1 Never Married 2 Married Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: "natural", Specify White Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Mobile Home Park 12 Manager e 1 and 2 should be filed wit of Health and Mental Hygie If item 27 is marked other or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Agusta Newman Lula May Smith permit. Page 1 and 2 should be Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12905A Molasses Road, Union Bridge, Maryland Karen Dotterer - Daughter 21791 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) injury or Mt. View Cemetery 4 Donation 5 Other (Specify) 10/20/10 Damascus, Maryland 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home 21. Signature of Fun ral Service LT 26401 Ridge Road, Damascus 20872 23a. Part 1. Enter the disease, or complications that cau d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ne. Approximate Interval Between Oset and Death Immediate Cause (Final renome. Pnysician/ disease or condition moulle Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of): the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical that the death certificate be Box 68760 use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy ned by the atten detached for u in the past 12 m Month Pregnant at time of death 5 Other (specify) Yes No P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Division of Vital Records, The law requires Completed 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Yes 2 No Yes or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2/ No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this completed filled in by the funeral 27. Manger of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 2 Accident (Month, Day, Year) 5 Pending work? 1 🗌 Yes 2 🗌 No 24 hours after death Funeral Director: A Investigation Could not be 3 Sulcide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 the only one 29d. Date signed (Manth, Day, Year) 29b. Signatu of certifie and ti n who completed cause of death (Item 23

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32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Lisa Ann Cundiff 10 2010 30P Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** 1909 Monument Rd. Frederick Myersvill 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs Funeral Country)
MD Days Hours 7/14/1969 1 M 2 X F 217-86-9178 41 Yrs. Director Usual Residence of Decedent show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County filed within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director FL Leesburg Orange 1 ☐ Yes 2X No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 10221 34788 Patrick Dr. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify. 3 Widowed 4X Divorced Year or Dates 16a. Decedent's Usual Occupation 16b, Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) federal Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. Iant: If item 27 is marked other than lury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) <u>dental assitant</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Beverly E. Wood Robert L. Miller 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 253~W.~5th~St.,~Frederick,~MD~2170119a. Informant's Name/Relationship (Type, Print) Robert Miller (Father) 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ott cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Union Cemetery 10/16/20 DBurkittsville, MD 4 Denation 5 Other (Specific Signy nure of F neral Service Lio ²² Donald B. Thompson Funeral Home MD 21769 POB 18. Middletown. 233 Part 1. Enter the disease, accomplications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause of sach line. Approximate Interval Between Onset and Peath Immedia Caus (Final disease o ond tion resulting in death) Physician/ Medical Due to (or as a conse uence of Examiner Sequentially list conditions, Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FÉMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death 9 Unknown Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a, Was an death? 1 Yes 2 No Yes 2 Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 | No 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ 28a. Date of injury (Month, Day, Year) 28b. Time of 28d, Describe how injury occurred Victim hanged Self 27. Mariner of Death 28c. Injury at Certificate: 1 Natural 5 Pending UnknowM 1 Yes 2 No Cord October 11,2010 extension 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 13 City or Town, State) at home 1909 Monument Rd, Myers nike MD Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29b. Signature and title of certif

31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regist

ar's Signature

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 34571 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 2010 11:00 A M **Physician** MILES CHRISTY I6, JUNE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Somerset Crisfield 4303 Cullen Parkway If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/18/1930 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 1 □ M 2 🕱 F Maryland 215-26-5762 80 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exerciper must be research once. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Crisfield Maryland Somerset 1 ☐ Yes 2 X No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21817 U.S.A. 4303 Cullen Parkway Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 □Yes 2 ☑ No Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No If Yes, Give Year or Dates Specify Specify: White ģ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lena May Ward James Edward Miles 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #4 Rolling Lane - Flemington, N.J. 08822 Glenn M. Riggin (Executor) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Crisfield, MD 10/23/2010 Sunnyridge Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Pineral Service Licent 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, MD 21817 Bradshaw, Jr. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final rabetes **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Exami attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🔲 Yes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1 □Yes 2 funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Vanner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Natural 5 Pending investigation s after dea. 1 □Yes 2 □No Accident 6 Could not be within 24 hours after des To the Funeral Directo completely filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 9.2010 30. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print) Huddleston, M.D. 106 Milford Street - Salisbury, MD 31. Date filed (Mor State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2, Date of Death Month Physician/ Francis Michael Collins, Jr. 1:22 Αм October 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5614 Hawthorne Street Prince George's Cheverly 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, 1 🖾 M 2 🗆 F Months Hours Min Troy, New York 95 216-16-1472 Director February 6, 1915 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Prince George's Cheverly Maryland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral with 5614 Hawthorne Street 20785 USA should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 Nidowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) NASA nd Mental Hygier Aeronautical Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Francis Michael Collins, Sr. Elizabeth Bohrer and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Heatth a
Important: If item 27 is
any injury or other tra Francis Michael Collins, III / Son 5614 Hawthorne Street, Cheverly, MD 20785 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Resurrection Cemetery 10/21/2010 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Kugu) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Congestive Heart Failure disease or condition resulting in death) Years Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Years Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) that the death certificate be executed burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last physician a Physician/Medical Records, P.O. Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ģ Month Day 4 Pregnant : 9 Unknown Pregnant at time of death 5 Other (specify) Yes 2 No the detached g Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş or Attending Physician: The law requires cate has been signated by page 2 should b 1 ☐ Yes 2 🛛 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy perform certificate I Yes 2 X No Division of Vital 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 🗷 Residence 6 🗌 Other (Specify) Hospital: 2 🔀 No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 \square Pending injury within 24 hours after death.

To the Funeral Director Af
completed filled in by the fu 1 Tes 2 \square No Accident Investigation in by the Suicide
Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State, Hospital Medical

State

Registrar DHMH 17 Rev 7/2009 29a. Certifie (Check

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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30. Name address of person who completed ca

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Certifying Nurse Practioner: To the best of fr

of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledgy, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause

29c. License number

d/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d, Date signed (Month, Day, Year)

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knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month / 9:20 M DAVID 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Pince 9 HOSPITIAL CUINTON MARYLAND SOUTHERN If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Country) 5.C 1 🕱 M 2 🗆 F Months Days Hours Min. Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a, State within 72 hours after death with the Maryland Funeral Director SUITLAND Yes 2 No HD) 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? KOAD 20146 LARK SPUR USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 No Maryland 21215-0036 1 Yes 2 No Specify. Specify: BLACK If Yes, Give Year or Dates 3 Widowed 4 Divorced "natural" Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) and Mental Hygiene. event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Menta Important if item 27 is marked v any injury or other traums*** ည DAVIO CARROL, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SISTER SUITZANO. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 10.23.10 RIVERCULE Park Crunatory 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 11001 014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CHRONIC Immediate Cause (Final OBSTRUCTIVE PULMONARY Priysician/ DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Records, P.O. Box 68760 as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 9 Unknown 5 Other (specify) signed by the at d be detached for Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1.

NEUMONIA HYPERTENSLON 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available page 2 s autopsy prior to completion of cause of death? performed? Yes 2 ☑ No 1 Yes 2 No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Ai completed filled in by the fu Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town. State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) ATTENDING PHYSICIAN D 52900 10-16-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RD #205 GLENN DALE MD20769 12150 ANNAPOLLS MD MOMOH 32. Registrar's Signature Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 45 M 10 Prnice Medical 4a. Facility Name (if not institution, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** touse Arlace HügerTOWN Washinstor 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Funerai (Month, Day, Yo 1 □ M 2 🛛 F Hours Min 489-05-8813 Sep. Director Missouri Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington County Hagerstown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10116 Sharpsburg Pike 21740 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 ☐ Yes 2X No Specify. Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates. 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. Furniture Company Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) n and Mental I ဂ Willy Wand Shaeffer Kyle John Kyle permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Wunderlich-great-nephew |18513 Wagaman Rd. Hagerstown, MD 21740 injury or other 20a. Method of Disposition
1 ☐ Burial 2 ី Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Smithsburg, Maryland Smithsburg Crematory 10-21-2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Corchary 1905 Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a cons Examir attending physician and for use as the bunal-transit The law requires that the death certificate be executed anemia that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 刭 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N has 2 No 1 Tyes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hosisted Other: 1 \(\text{Yes} မ 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Sp. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1XX Natural 5 Pending work? 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the within 2 29b. Signature and title of certific DO063995 MD 10/30/10 30. Name and address of person who co pleted cause of death (Item 23a) (Type, Print)

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien

			For State Registrar	State of M	aryland		rtment tificate			ınd Me		gien e Reg. No.	10	34575	
	Physicia		Decedent's Name (First, Middle, Last) JENNIFER CHARLES								Date of De	ath 17, ^D 2010	Year	3. Time of Death 8: 30A M	
	/Medic Examin		4a. Facility Name (If not institution, give s 8875 DARLEY DRIVE	treet and number))		4b. City, Town, or Location of Death LA PLATA				4c. County of Death CHARLES			1	
	Funeral Director		5. Social Security Number 6. Sex	M 2 1 7. A	ge (In yrs. la 58	a <i>st birthd</i> ay) Yrs.	If Under 1 Months	Year Days	Hours	Min. 8	NOV • 8	th , 1951		pplace (State or Foreign	_
	laryland show	or	Usual Residence of Decedent 10a. State 10b. County MD CHARLES		10c. City	, Town or Loc								10d. Inside City Limits 1 ☐ Yes 2 No	
	with the N Sa or 28a-1	Funeral Director	10e. Street and Number 8875 DARLEY DRIVE				10f. Zip 0	Code 2064	6				of What Co		_
5-0036	I within 72 hours after death with the Maryland jiene. ithen "natural", or items 23a or 28a-f show the Macified Examinational Le rotified at	þ	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Armed Forces 1 ☐ Yes 2 M If Yes, Give Year or Dates:	? No	l II	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □Yes 2 □ No Specify:						14. Race - American Indian, Black, White, etc. Specify: BLACK		
121	within ene. than "	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or	5+)	(Give l life. E	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ACCOUNTANT						NON PROFIT		
Maryland	Pages 1 and 2 should be filed nent of Health and Mental Hyg ant: If Item 27 Is marked othe ury or other traumatic event,	To Be C	17. Father's Name (First, Middle, Last) UNKNOWN						ANIT	ra CH	ARLES	irst, Middle, Maiden Surname) RLES			
			19a. Informant's Name/Relationship (Ty, LEONARD THOMAS/HUS			8875	DARLE	Y DR	IVE,		LATA,	MARYLA	ND 2	0646	_
altımore,			20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	temoval from State Cometery, crematory or other place)											
Ra	permit. Departr Importa any inji		21. Sign v. e . Fun t Service License LYDIA C. THORNI	ON JOHNSO							_		YLAND 2		
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ds, P.	law requires that the death as been signed by the atter 2 should be detached for u	5	Part II. Other significant conditions con	ntributing to death	but not resu	ulting in the u	nderlying ca	ause give	n in Part I			tobacco use]Yes 2 ☐ I		the cause of death?	
Vital Records,	The ate h	Completed		-				·			24a. Wa aut per 1 ⊡Yes	opsy formed?	prior to death?	utopsy findings available completion of cause of	
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Division of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification: To	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of libuilding,	njury - At ho etc. <i>(Specif</i>	ome, farm, str (y)	reet, factory,	, office	827	2	8f. Location City or To	(Street and I own, State)	Number or R	ural Route Number,	
	Hospita 24 hours Funera etely fille	edical C	29a. Certifier 1 CertifyIng Phy (Check only one)	sician: To the bes	of examina	owledge, deat ation and/or in	h occurred vestigation	at the tim , in my or	ne, date a pinion, dea	nd place, a ath occurre	and due to the	ne cause(s) a e, date and p	nd manner a ace, and du	s stated. e to the cause(s)	
	To the vithin To the compl	Me	29b. Signature and title of certifier	M.			290	. License	number	21	^ >	29d. Date :	signed (Mon	th, Day, Year)	_
	287		30. Name and address of person who c	ompleted cause of	death (Iten	n 23a) (Type,	Print)	2		P)	cho	- 1	10	2066	
	Sta	ate	31. Date filed (Month, Day, Year)	1	strar's Signa	ature A	barke	,		, .				0 \	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Cole MAN OCTOBER 9:48 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGE'S 5. Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Hours Month Day Ye 1 XM 2 F Months Days VIRGINIA **Director** 224-68-6221 63 1947 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. ant. If item 27 is marked other than "natural", or items 23a or 28a-1 show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No PRINCE GEORGE'S FORESTVILLE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 2315 WINTERGREEN AVENUE 20747 USA Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣No BLACK 3 Widowed 4 Divorced Completed Year or Dates ed other than "nature event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8TH MECHANICAN PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ HARRY L. COLEMAN SR. SUE E. DICKERSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY A. COLEMAN/WIFE 2315 WINTERGREEN AVENUE FORESTVILLE, MARYLAND 20747 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riceville Cemetery 10-22-2010 Java, Virginia 22. Name and Address of Facility 7474 Landover Road, 21. Signal 1e of Funeral Service Licensee Landover Md. JB Jenkins Funeral Home 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph_sician/ erebral Medical resulting in death) Examiner arter Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Cause (Disease or linjury that initiated events pertension burial-tran Due to (or as a consequence of resulting in death) Last To the Funeral Director, After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the buria Diabetes Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Dav Other (specify) Pregnant at time of death 5 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Yes 2 🗆 No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy
performed?

1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury work? Accident Investigation 2 No 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier D69983 10,15,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Herbert Marshall Dye, Sr. October 22, 2010 8:50 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Western Maryland Regional Medical Center Cumberland Allegany If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year 9. Birthplace (State or Foreign Funeral 1**Ø**M 2□ F Days 219-14-5414 Maryland Director 86 October 23, 1923 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ir than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Funeral Director Midland Maryland Allegany 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 19320 Paradise Hill Lane 21542 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: Specify: Completed by 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Supervisor Mill Room 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ont of Health and Mental Hit if item 27 is marked oth y or other traumatic event Be Herbert Wilbert Dve Ruth Miller ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Dye - Wife 19320 Paradise Hill Lane, Midland, Maryland, 21542 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition October 26, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Frostburg Memorial Park 2010 Frostburg, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A Grandile 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to lor as a consequence of or Attending Physician: The law requires that the death certificate be executed oronan Due to (or as a consequence of Box 68760. Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) P.O. After this certificate has been signed by the tuneral director, page 2 should be detached 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed res 2 2 □ No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 hpatient 2 ER/Outpatient 3 DOA Certification; To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending death. 2 Accident investigation 1 ☐Yes 2 ☐No within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 😾 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 26 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 16:00 PM October 2010 Anthony D. DiMauro 14 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Street Harford Hart Heritage Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 X M 2 □ F Maruland Director 11/08/1927 213-20-8755 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 28a-f show d other than "natural", or items 23a or 28a-f shovevent, the Medical Evening must be notified at 1 ☐ Yes 2 👿 No Director Peach Bottom Lancaster 10g. Citizen of What Country? 10e. Street and Number Funeral 9 Joy Lane 17563 U.S.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Armed Folces: 1 Myes 2 □ No If Yes, Give Year or Dates: 1946-46 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) 10 Civil Service Ammunition Foreman permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if Item 27 is marked othe any injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Biaggio DiMauro Josephine Marchioni ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christina L. Payne (Daughter) 9 Jou Lane. Peach Bottom. PA 17563 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St.Catherines Cath. 10/21/2010 Quarryville, PA 22. Name and Address of Facility Reynolds Funeral Home, P.A. 21 Signature of Funeral Service Licensee 144 E. State St., Quarryville, PA 17566 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Remem/1A 40.121 **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncerning Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine executed and burial-trar Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hiknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? assisk D Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 2 No 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral dit 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🗂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of-qertifier 29c. License number

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SPANKS

egistrar's Signatu

FRAD

39889

W. MACPHAIL RIS BELAIN MS 21014

Oc1234/9, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 1^{Day} , 201^{Te} Gerald James Dempsey 9:20 РМ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Northampton Manor Care & Rehab Center Frederick Frederick Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XXM 2 □ F Months Days Hours Min. (Month, Day, Year 178-26-5592 Director 74 Ĭ936 Pennsylvania Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Maryland 1 X Yes 2 No Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 200 East 16th Street 21701 United States 12. Was Decedent Ever in U.S.

Armed Forces?

1 88 Yes 2 □ N

1 Yes, Give
Year or Dates. hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ≥ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 KX No Specify. Specify: White 3 ☐ Widowed 4 M Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ge 1 and 2 should be filed within 7; t of Health and Mental Hygiene. If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Non-Commissioned Officer United States Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Dempsey Grace Carroll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jason Dempsey / Son 13428 Northwest Ct., Haslet, 76052 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot October 16. cemetery, crematory or other place)
Restnaven 1 XX Burial 2 Cremation 3 Removal from State Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 Memorial Gardens rice Licasee 21. Signature E Resthaven Funeral Services, 9501 Catoctin Mountain Hwy. Skkot Cody P.A. Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Cerebro Visculan Physician disease or condition ساعت W Medical resulting in death) Due to (or as a consequence of): Examiner perfension Sequentially list conditions if any learning cause. Enter Underlying Cause (Disease or iinjury that initiated events Examin sician and burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Pregnant at time of death Year Yes 2 No been signed by the should be detached 9 Unknown 9 Linknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performed? Yes 2 X No this certificate 2 🗌 No After this certific funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 😾 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4

Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending work s after death.

I Director: Aff
d in by the ful 1 🗌 Yes 2 🗀 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours af

To the Funeral Di

completed filled in Hospital Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 43091 10-14-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CTIVA 801 Toll House Ave., Saeed Zaidi, M.D. Frederick, MD 21701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Belo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 34580 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Sept. 2010 Katherine Durand 11:05 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Sanctuary at Holy Cross Montgomery Burtonsville Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Month, Day Yea March 22, Days 1 ☐ M 2 🔀 F Months Hours Pennsylvania 79 1934 **Director** 005-28-4646 Usual Residence of Decedent 28a-f show er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20852 12413 Braxfield Ct. United States Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. and Mental Hygiene. is marked other than "natural", or 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give 3 Widowed 4 Divorced Specify: Completed White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) within 72 Elementary/Seconday (0-12) College (1-4 or 5+) Dog Groomer Pet Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be find Health and Mental item 27 is marked Walter J. Kressley Acponia Schilling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 407 Twinbrook Pkwy, Rockville, MD 20851 Barry Durand, Son permit. Page 1 and 2 Department of Healt Important: If item 2 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ft. Lincoln Crematory: 10/8/2010 Brentwood, Maryland 21. Signature of Funeral Ser 22. Name and Address of Facility Simple Tribute M01463 any 1040 Rockville Pike, Rockville, MD e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part 1. Enter the dis shock, or neart failu Immediate Cause (Final disease or condition the dis Approximate Interval Between Onset and Death Schemuc Pnysician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physiciar Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 as the IF FEMALE: Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No ō Day Month Year been signed by the a should be detached the 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed Yes 2 No 1 ☐ Yes 2 ☐ No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Norsing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 2. No 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.

Funeral Director: After this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No. Investigation Accident 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

2835 Smith Avenue.

Sule 203 Ballinine

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

OCT 1 4 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) October 7° 2010 2010 Physician/ Deffenbaugh 2:30A. Durward J. Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Silver Spring Montgomery Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**∑** M 2 □ F Days Jan. 21 1927 Akrony, Ohio 83 216-22-6293 Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County Director Kensington Maryland Montgomery 1X Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? ō 10e. Street and Number Iral", or items 23a or Examiner must be Funeral 20895-2515 United States 10608 Nash Place within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U.S Armed Forces?
1 X Yes 2 □ N Black White etc. "natural", or 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates. the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Mont. Co. Schools Pupil Personnel Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Celese Blank Durward Deffenbaugh other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Helen Deffenbaugh -wife 10608 Nash Place Kensington, Maryland 20895-2515 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ACremation 3 Removal from State Metropolitan Crematory 10/9/2010 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Signature ners Serve licensee Maryland 20705 14400 Powder Mill Road Beltsville, Maryland 20705 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Retween Onset and Death Immediate Cause (Final Physician/ Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Aspiration Pneumonia Securitally list randitions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): requires that the death certificate be executed Dementia and Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown 2 No signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Prostate Cancer; Chronic Lymphocytic Leukemia. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Coronary Artery Disease 24a. Was an cate has b page 2 s autopsy performed? Yes 2X No Hospital or Attending Physician: The I 24 hours after death.
 Funeral Director: After this certificate h 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 【 No 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XInpatient 2 🗆 ER/Outpatient 3 🗆 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident completed filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the F only one) 29c. License number 29d. Date signed (Month, Day, Year, 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

14

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DHMH 17 Rev 7/2009

32 Registrar's Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Satyam A. Shah, M.D. HCH 1500 Forest Glen Road Silver Spring, Maryland 20910

D68096

October 8, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October Evelyn 1625 PM Maru Deibert 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery General Hospital Olnw Montgomeru 9. Birthplace (State or Foreign Country) Pennsylvania Social Security Numb If Under 1 YeaU If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 1 □ M 2 🛣 F Days (Month Day Director 199-20-7941 Usual Residence of Decedent 28a-f shov 10a. State 10b County 10c, City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Silver Spring 1 Yes 2 No Maryland Montgomery 10e, Street and Number 10f. Zip Code ö 10a. Citizen of What Country? Funeral 23a 3112 Regina Drive 20906 U.S.A permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event, the Medical Examiner musting injury or other traumatic event, the Medical Examiner musting injury or other traumatic event, the Medical Examiner musting injury or other traumatic event, the Medical Examiner musting injury or other traumatic event, the Medical Examiner musting injury or other traumatic events. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black White etc. 1 Never Married 2 X Married ğ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. Specify: 3 Nidowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert D. Bailey, Sr. Ruth I. Kuhn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3112 Regina Drive, Silver Spring, Maryland 20906 Horace E. Deibert. Jr./Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Q Other (Specify) Gate of Heaven Cem. 10/22/2010 Silver Spring. MD 21. signatur of Funeral 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 23a. Part 1. Enjor the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (5 had disease or condition resulting in death)

a. Sepsis 11800 New Hampshire Ave., Silver Spring, MD 20904 Onset and Death Physician. Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): ending physician and use as the bunial-transit requires that the death certificate be executed acidosis that initiated events resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No ō 1 Yes 2 D Month Day Year Pregnant at time of death 5 Other (specify) been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law page 2 performed After this certificate 1 Yes 2 X No 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 2 X No မ 1 🔲 Yes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending after death. 1 Yes 2 No Accident Investigation 6 Could not be within 24 hours after de To the Funeral Directo S completed filled in by th Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 □ only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 754996 Bichhuon 10 October 17 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18101 Prince M'u 20832 egistrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11:51a M Patricia Ann Dillon October Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Asbury Methodist Village Gaithersburg Montgomery 8. Date of Birth (Month, Day, Year) 09/17/1924 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1 M 2 12 F Months Days Hours Washington. DC Director <u>579-26-</u>1952 86 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Frederick Maryland Frederick 10f. Zip Code 10g. Citizen of What Country? Funeral 6351 Spring Ridge Pkwy., 21701 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🗶 No Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 X Widowed 4 Divorced Completed White Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 1 and 2 should be filed within 72 f Health and Mental Hygiene. item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Sales Coordinator Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Ambrose F. Higdon Mary E. Brooke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 6351 Spring Ridge Pkwy., #125, Frederick, MD 21701 Christine M. Dillon - Daughter injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Durial 2 X Cremation 3 Removal from State 4 Denation 5 Other (Specify) Lincoln Crematory 10/20/2010 Brentwood, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Simple Tribute & Cremation Ctr. 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Years Pnysician/ Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) sician and burial-trans Due to (or as a consequence of) resulting in death) Last physician a Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1
Yes 2 No Month Day Year been signed by the should be detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Hospital or Attending Physician: The law autopsy performed?
Yes 2 X No page 2 : this certificate 1 Yes 2 No Be (funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2 🗶 No ဂ္ 1 Inpatient 2 I ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at s after deau.
al Director: After law the firestor. 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor **To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

— Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) October 18, 2010 D20148 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Gaithersburg, Maryland 20879

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12º9 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** Charlie Dancy october 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Thomas Moore Nursing Facility Hyattsville Prince Georges If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 78 Yrs. Birthplace (State or Foreign Country) Social Security Number 246–38–4951 **Funeral** Days Hours 1**⅓**M 2□ F 12-10-1931 NC **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Nedical Examinar must be notified at Washington DC 1√2 Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number within 72 hours after death with 2632 Monroe Street NE 20018 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black White, etc. 1⊠Yes 2 No 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Yes. Give Specify: Black þ 3 Widowed 4 Divorced Year or Dates: 1953-1955 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) if Health and Mental Hygiene. Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Govenment 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Paul Dancy Mary Austin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Editha Dancy Wife 2632 Monroe Street NE Washington, DC 20018 20b. Place of Disposition (Name of cemptery, crematory or other place)

Quantico National Cem 10-22-2010 Triangle, VA 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 permit. Pages 1 Department of H Important: If Ite 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) any injury 22. Name and Address of Facility 21. Signature of Funeral Service Licens Bianchi 814 Upshur St NW Washington, DC 20011 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Years **Physician** tenioso disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions. in any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to tor as a consequence of Examiner executed sician and burial-tran Due to (or as a consequence of): Box 68760. attending physician the death certificate be Physician/Medical the as IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy or Month Day Year 5 Other (specify) ☐Yes 2☐No ed by the detached Ö 9 Unknown ۵. signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 TUnknown centalogaThy Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☐ No Disease Cenebral Infanction Chronic Kidney certificate 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 • To the Hospital or Attending within 24 hours after death. 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident npletely filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier **Medical** 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) License number 29b. Signature and title of certifie 10 completed cause of death (Item 23a) (Type, Print) usbury Rd beyatt sville Mi)2018/ 30. Name and address of 31. Date filed (Month, Day, State

Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Enright Shirley Ann 2010 7:10 October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery 19036 Jamieson Drive Germantown If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1 🗆 M 2 🗓 F Months Davs Hours Min. 333-38-4267 68 Country) T11**inois** Director <u>August</u> Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director MD Montgomery 1 🗆 Yes 2 🔀 No Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19036 Jamieson Drive 20874 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. δ 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", White Specify: 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 lith and Mental Hygiene.
27 is marked other than r traumatic event, the Mr Elementary/Seconday (0-12) College (1-4 or 5+) Professor Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Leathers Olympia Zimny 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau once. Timothy D. Enright/ Husband 19036 Jamieson Drive, Germantown, MD 20874 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State All Souls Cemetery Germantown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee 22. Name and Address of Facility
DeVol Funeral Home, 10
Gaithersburg, East Deer Park Drive, RACY M01117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Death
2 Years shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Breast Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or se a noneequenes or): Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown for Day Month Year io the Funeral Director, After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 👿 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 🔀 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 XResidence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Yes 2 No 2 Accident 3 Suicide s after death Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Contifying Nurse Production to the best of my hornedge, seath occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) ID MD D0061083 October 12, 2010

Registrar

31. Date filed (Month, Day, Year)

37 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Paul Thambi, M.D., 9707 Medical Center Drive, Suite 300, Rockville, MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Fvans** Josephine Ottober 14, 2010 Physician/ 8:16P. M Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Beltsville 13105 Flint Rock Drive . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral Months Days Hours Min. Sept. 22, 1919 1 🗆 M 2 💢 F Maryland 578-58-7329 91 Director Usual Residence of Decedent 10b. County 10c. City Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at within 72 hours after death with the Maryland Director 1 Tes 2 X No Beltsville Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20705 United States 13105 Flint Rock Drive 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black "natural", 3 XWidowed 4 ☐ Divorced Year or Dates. er than "natura the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) and Mental Hygiene. Statistical Clerk Federal Government is marked other aumatic event, th permit. Page 1 and 2 should be filed or Department of Health and Mental Hyg Important: If item 27 is marked othnany injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benjamin F. Harrison Bessie J. Boyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 308 Charter Oak Avenue Baltimore, Maryland 21212 Sheila T. Grimes -Niece Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
MD National Mem. Park 10/23/2010 Laurel, Maryland 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Dowared of Borgwardt Funeral Home, 4400 Powder Mĭll Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Dehydration disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Hypotension Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Litter University Cause (Disease or iinjury attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed <u>Diabetes Mellitus</u> that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Vear 1 Yes 2 No Pregnant at time of death been signed by the should be detached g | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Deconditioning secondary to poor appetite; 1 ☐ Yes 2 💯 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of Generalized weakness 24a. Was an has autopsy performed?

1 Yes 2 No death? 1 ☐ Yes 2 🕅 No certificate Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA ည 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) October 15, 2010 D67891 Si Name and address of person who completed cause of death (Item 23a) (Type, Print) Simona Sirbu, M.D. 1776 Powder Mill Road Silver Spring, Maryland 20903

State Registrar 31. Date filed (Mo

egistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 34587 Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death October 2010 Physician/ 3:30 PM lomas am Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George Regional Hospita aure aure If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 5. Social Security Number Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 X M 2 □ F Months Davs Hours Min. (Month, Day, Year, uly 27, 1 Washington, 577-38-8063 84 1926 Director Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State filed within 72 hours after death with the Maryland Director Examiner must be notified 1 X Yes 2 No District Heights Maryland Prince George's 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 23a 20743 2100 Brooks Drive, #714 USA "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Bace - American Indian. 11. Marital Status rmed Forces?

XYes 2 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates White Completed 3 Widowed 4 Divorced WWII Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) C&P Telephone the Installer 12 Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thomas Elam Theresa Popp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12001 Old Columbia Pike, #810, Silver Spring, MD 20904 Charles H. Elam / Brother 20c, Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 10/20/2010 Alexandria, Virginia Metropolitan Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 36 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as-a consequence of) Examiner 2 CA 2001 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Other (specify) Pregnant at time of death Unknown signed by t d be detach Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 3 Probably 4 Unknown 1 Yes 2 No Completed page 2 should been s 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform 1 ☐ Yes 2 X No certificate Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Yes 2 **X**No 욘 1 🗙 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 2 🗌 No Investigation Accident filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town. State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Registrar DHMH 17 Rev 7/2009 29b. Signature and title of certified

31. Date filed (Month, Day, Year

OCT 2 0 2010

Mohamed

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

Tourky,

-aurel

29c. License number

Regional Hospita

29d. Date signed (Month, Day, Year)

MD

Van

7360

Dusen Road

20707

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month October 0 11:30 A^M Lawrence Howard Edwards Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death South River Health & Rehabilitation Edgewater Anne Arundel If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 😿 M 2 🗆 F Nov. 13 Hours Virginia Director 579-20-9248 Usual Residence of Decedent 3a or 28a-f show t be notified at 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 1 Yes 2 No Calvert Dunkirk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a USA 2830 Feather Ridge Court 20754 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 M Yes 2 □ No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Specify: Year or Dates. 1942-46 white traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Billing Customer Service Manager Gas Utility Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o မ Ruth Elizabeth Randolph Edwards. Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) D. Diane Cifizzari, daughter 2830 Feather Ridge Court, Dunkirk, MD 20754 or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I Important: If its 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury c MD Veterans Cemetery: 10-21-2010 Cheltenham, MD 21. Signature of Europal Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to or as a consequence of): **Examiner** YSD1091 Sequentially list conditions, Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury use as the burial-transit Houte Cerebro Vascular that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by AOTHIC Stenosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown myo (andial infanction 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director; After this certificate h performed' death? 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဂ္ 1 Inpatient 2 I ER/Outpatient 3 I DOA funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) Suranci. D. 50653 10-15-2010

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DHMH 17 Rev 7/2009

Registrar

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C.

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra

Deale

			Please	Type or Print in						•		•	
			For State	State of Maryl	and / [ntal Hy	giene	2010	34589
			Registrar 1. Decedent's Name (First, Middle, Las	et)		Cert	ificate of	Death		Date of Dea	Reg. No).	3. Time of Death
	Physicia /Medic		Dorothy	Ever	har	+			0	Month, Clobe	Da		5:30 AM
,	Examin		4a. Facility Name (If not institution, give	11	1 /	2	4b. City, Town, o	r Location	of Death		40	County of Death	1
, 4	Funeral		5. Social Security Number 6. S	ex 7. Age (In	yrs. Jas bir	thday)	HQQ -CI) () r 24 Hrs. 8.	Date of Birt (Month, Da	th .	Uashir 9. Birth	ロイしい nplace (State or Foreign unitry)
	Director		219-12-2242	□ M 2 K F 85	0	Yrs.	Months Days	Hours	Min.	.2/23/	y, Year) 1924		yland
2	yland how		Usual Residence of Decedent 10a. State 10b. County	10c	. City, Tow	n or Loca	ation						10d. Inside City Limits
N	ges I and 2 should be lifed within 7 a hours after beam with the maryland ges I and 2 should be lifed. It should life them 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, it is the life of the should be a l	Director	Maryland Washingt	on H	agers	towr	1						1 □ Yes 2 No
4	with the	Dire	10e. Street and Number		-		10f. Zip Code					tizen of What Co	untry?
4	ms 23	Funeral	8238 Dam #4 Road	12. Was Decedent Ever i	n U.S.	13. W	21795 as Decedent of F Yes, specify Cub	lispanic O	rigin? (Specif	y Yes or No		J.S.A. 14. Race - Amer	
2	or Ite		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 No If Yes, Give		1 .	Yes, specify Cub □Yes 2 X No	an, Mexica Specify		an, etc.)		Black, White	, etc.
	ural",	d by	3 Widowed 4 □ Divorced	rear or Dates:				, ,	,.				ite
2 5	"nat	Completed	15. Decedent's Ec (Specify only highest gra	de completed)	16a	Decede. Give ki life. D0	ent's Usual Occup ind of work done O NOT use retire	pation <i>during mo</i> d)	st of working	1	16b. k	(ind of Business/I	ndustry
7	Mental Hygiene. Mental Hygiene. arked other thar atic event, in a M	E O	Elementary/Secondary (0-12)	College (1-4or 5+)			Manag					Insuranc	е
	tal Hy	Be (17. Father's Name (First, Middle, Last)					18. Moth	ner's Name <i>(F</i>		Maider	n Surname)	
7	should be and Mental s marked c umatic eve	၉	Fred Boward					Mari	ion Fo	1tz			
- 0	h and rism		19a. Informant's Name/Relationship (-	*					or Town, State, Z	
י ע	Health em 27		Linda Kaufman / Da 20a. Method of Disposition	ughter					<u>illiams</u> Date			yland 21 ocation - City or	
5	perint. rages fand a Department of Health Important: If item 27 any Injury or other tr once.		1 Surial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	nemoval from State			tion (Name of atory or other place	i		- 1			
	Department Department Important: I any Injury o		21. Signature of Funeral Service Licer		ose r		Cemeter Name and Addre		10/23/ lity Rest	Haven	Hage	erstown neral Ch	Maryland
Ď	Depa Impo any l		16 4.	Sron									ryland 2174
		2	23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the cone cause on each line.	death. Do	not enter	the mode of dyi	ng, such a	s cardiac or re	espiratory a	rrest,		Approximate Interval Between
	hysician	02 33	Immediate Cause (Final disease or condition	a Chmu	io	bel	rugni	e d	lines	~			Onset and Death
	/Medical xaminer		resulting in death)	Due to (or as a con	sequence	of):	. +		prin				16.00
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a con	sequence	of):	perale	Cr.	prim	an	ev	4	(yew
over Hed	nd ransit	Examiner	that initiated events	C.									
, 2	1 2 2 2	EX	resulting in death) Last	Due to (or as a con	sequence	of):							
of of or	attending physic for use as the b	dica	•	d									
7 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	anding use a	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pro								23d. Date of del	ivery
1	he atte	Physician/Medica	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown			Ectopic pregnand Other (specify) _	cy				Month	Day Year
, tag	d by the	Phy	9 ☐ Unknown Part II. Other significant conditions of		reculting i	n the unc	derlying cause giv	en in Part	1	23e Did t	ohacco	use contribute to	the cause of death?
Lo,	been signed by the should be detached	d by		on a paining to dead a pat not	resulting ii	ii tiio diio	ionymy dause gn	remini an					obably 4 Unknown
	as bee 2 shou	plete								24a. Was		24b. Were au	topsy findings available
The	cate has	Completed								autor perfo 1 □Yes	rmed?	death?	completion of cause of 2 No
V 110	th. After this certificate I funeral director, page	Be	25. Was case referred to medical examiner?	Magnitoli			100		ce of Death (C	Check only o	ne)	·	
2 4	this ral dir	P.	1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 28a. Date of Injury		utpatient Time of		4 LyP(6 ☐ Other (Spe	cify)
j - j	th. : Affe	ition	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Yea	ar) 200.	Injury	28c. Inju Wor M 1 🗆	rk? R?]Yes 2[i. Describe i	now inju	iry occurred	
Atte	ector by the	Certification:	3 Suicide 6 Could not be determined	i	At home, fa	ırm, stree							ural Route Number,
5 <u>5</u>	ins after									City or To			
the Hochital or Attending Division. The law requires that the death certificate	within 24 hours after death. To the Funeral Director: A completely filled in by the to	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	nysician: To the best of my niner: On the basis of examination and manner stated.	knowledge mination ar	e, death nd/or inve	occurred at the testigation, in my	ime, date opinion, de	and place, and eath occurred	d due to the at the time,	cause(date ar	s) and manner as nd place, and due	s stated. e to the cause(s)
To the	within To the	Med	29b. Signature and title of certifier	and manner states.			29c. Licens	se number	,		29d. D	ate signed (Monta	h, Day, Year)
			Maryon	gray				D2	8365		10	2011	C
411	. 7		30. Name and address of person who		(Item 23a)	(Type, P	rint)	150	C+	1 - 11/2	ve in		0 0 21740
5H	3 Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's S			68 ni	ul	FIRE	ME	JSK	in !	
	Registr		OCT 22 2	010	1	Men	and I						
				1	100	100							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 17 Physician/ 6:29 A M Lucy Mae Eason 2010° Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Prince George's Clinton If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country)
 NC. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 223 56 0574 Juneth, 25, 7942 1 □ M 2 🔀 F 68 Director Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Exminer must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No MD Prince George's Temple Hills 10g. Citizen of What Country? USA 10e Street and Numbe 20748 Funeral 6526 Beechwood Drive 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Armed Force Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Public Schools Custodian Be 18. Mother's Name (First, Middle, Maiden Surname)
Dora Lassiter 17. Father's Name (First, Middle, Last) ٥ John Eason 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6526 Beechwood Dr. Temple Hills, MD 20748 Joyce Eason/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Carvers Park Cemetery 10/23/2010 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Murfreesboro, NC 22. Name and Address of Facility Hertford County Undertakers 416 South Main St. Winton, NC 27983 Signature of Funeral Service Licensee 23a. H rt 1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause of each liny. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events. Due to (or as a consequence of): death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE yes, outcome of pregnancy
Live Birth 2 Petal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown the 9 Unknown 2 s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No To the Hospital or Attending Physician: The 2 🗌 No this certificate 25. Was case referred to medical examiner? **Division of Vital** 26. Place of Death (Check only one) Be Hospital: Other: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral o 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: At 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 1/Coertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifi 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Box 68760

P.O.

Records,

32. Registrar's Signature

10-07910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

uke E. Foster		1- For State Registrar	tate of Maryla		artment of rtificate of		nd Mentai		Reg. No. 201	0 3459			
Physic Medical Exam		Decedent's Name (First, Mide						2. Date of Dea Month	ath Day Year	3. Time of Death			
vieuicai Exam	mer	Luke Edwa 4a. Facility Name (if not instituti			1.	4b. City, Town,	or Location of D	October 1	14, 2010 4c. County of De	1744 hrs			
		Prince George's Hos	pital			Cheverly			Prince George's				
Funeral Director		5. Social Security Number 216-35-2809		7. Age (In yrs. I	The state of the s					Birthplace (State or reign Maryland			
		Usual Residence of Decedent	1 M 2 F	18	Yrs		March	13,1992	Country)				
/ amy		10a. State 10b. County		10c. City,	Town or Locati	ion				10d. Inside City Limits			
Aaryland 28a-f show 1 at once.	ğ	MD Montg	omery			Gaither	sburg			1 Yes 2 X No			
e Mary or 28a-	Director	10e. Street and Number 8213 Hedge Ap	-1- I/			10f. Zip Code	20879		10g. Citizen of What C	-			
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. *Red other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once.		11. Marital Status		edent Ever in U.	S. 13. Wa	s Decedent of H	(Specify Yes or No	United States r No- 14. Race - American Indian, Black,					
death or item must b	Funeral	1 X Never Married 2 N	Armed Fo	rces?				erto Rican, etc.)	White, etc				
rs after ural",	ģ	3 Widowed 4 Di 15. Decedent's Education (Spe	vorced If Yes, Give Year or Dates:			Yes 2X N	Specify:	White					
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12)				t's Usual Occup ost of working lit			16b. Kind of Busine	ss/Industry			
0036 within ene.	ldmo	12				Studer	it		High	School			
MD 21215-0036 and 2 should be filed within 7 lith and Mental Hygiene. Im 27 is marked other than aumatic event, the Medica	Be Cc	17. Father's Name (First, Middle Dave Alvin Fo	. ,					ame (First, Middle, I	· ·				
212 ould be I Ment i mark	To B	19a. Informant's Name/Relation		-	19b. Mailing	Address (Stre	Lee eet and Number	sa Nicho	o1s Number, City or Town, State, Zip Code)				
Baltimore, MD 2121/ permit. Pages 1 and 2 should be fil Department of Health and Mental I Important: If item 27 is marked injury or other traumatic event, I		Leesa Foster /	Mother		8213	Hedge A	pple Wa	y, Gaithe	ersburg, M	D 20879			
Baltimore, permit. Pages I an Department of Hea Important: If ites injury or other tr.		20a. Method of Disposition 1 Burial 2 X Crematio	n 3 Removal fro		rematory or oth	ition (Name of c ner place)	emetery,	Date ctober 21	20c. Location - City	or Town, State			
Itim nit. Pay artmeni ortanti		4 Donation 5 Other S 21. Signature of Funeral Service	pecify:	110	tropoli Crema	atory lame and Addres	ss of Facility	2010	Alexandri	a, Virginia			
Balti permit. Departm Imports		TRACY A. STU	112	M01117					ast Deer P. nersburg,				
Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause	complications that ca on each line.	used the death.	Do not enter th	ne mode of dying	, such as cardia	ac or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and			
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'60, rate be physici he buri	Medical	IF FEMALE:	23c. If yes, or	utcome of pregr	nancy				23d. Date of deliv	erv			
30x 6876 death certificat e attending phy I for use as the	sician/A	23b. Was decedent pregnant in the past 12 months?	1 Live bir	th nt at time of dea	2 Fet	al death 3	Ectopic pre	gnancy	Month	Day Year			
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Vita hysicis this ce	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 🗸 In	patient 2	ER/Outpatient		Othor:		Residence 6 Ott	ner:			
n of ding Ph. h. After tl	ü	27. Manner of Death 1 Natural 5 Pend	28a. Date o	f Injury Day,Year)	28b. Time of In FOUND:		ury at Work?	28d. Describe I Pedestrian s	how injury occurred struck by auto				
Division tal or Attendir s after death. al Director: A	ertification	2 Accident Inve	stigation Oct 10, 2		2135 hrs	t, factory, office	Yes 2 ✓ No			Rural Route Number, City			
Divi	Certi	4 Homicide dete	d not be	Local Stree		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		or Town, S		tara roate Hamber, Only			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical (29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best miner:On the basis of	examination an	e, death occurr nd/or investigati	ed at the time, o	late and place, a	and due to the caus	se(s) and manner as st and place, and due to	ated, the cause(s)			
	Me	29b. Signature and title of certifie	and manner sta	ited.		29c, Licen	se number		29d. Date signed (A	fonth, Day, Year)			
5		D_MO.				O.C.	M.E.		October 15, 20	10			
		30. Name and address of person Donna M. Vincenti, M				Penn Street	Baltimore	MD 21201					
St	ate	31. Date filed (Month, Day, Year)		istrar's Signatu	par	2)	., Daminore,						
Regis	rar	UCI 20	2010 Len	was p	· para								

OCME

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For	Pleas	e Type or State o		nd / Depa	artment	of Health	and M	II Copies Iental Hyg		_	€.		
		State Registrar 1. Decedent's Name	a /Eirot Middle	act)		Cei	tificate	of Death	1	2. Date of Dea	Reg. No	2010)	345	92
Physicia			argaret	Freebu:	rne					Month October		^y 2010 ^{ear}		3. Time of De 7 : 40P •	eath M
Medic Examin		4a. Facility Name (if Casey Hou	not institution, g				4b. City, To	own, or Location	n of Death		1	County of De	ath	ery	
Funeral Director		5. Social Security No. 505-50-31	LO4	Sex 1 ☐ M 2 X F	7. Age (In yrs.	74 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min. (Month Dec. 1			8. Date of Birth Dec • 19	Birth 9. Birthp Day, Year 35 Count 9, 1935 Iowa			ce (State or Fo	oreign
and show at	or	Usual Residence of 10a. State	Decedent 10b. County		10c. Ci	ty, Town or Lo	cation						10d	. Inside City I	Limits
Maryla 28a-f s	Director	Maryland	Montgo	mery	Si	lver S								1 🗌 Yes 2	X No
with the s 23a or ust be r	Funeral D	3122 Grac		Road, #C	T608	3 10f. Zip Code 20904			10g. Citizen of Wh United						
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hygiene. Department of Health and Mentall Hygiene. Department of Health and Mentall Hygiene. In the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	11. Marital Status 1 ☐ Never Marr 3 🏋 Widowed	ied 2 Married	Armed Fo	2 XNo	If Yes, specify Cuban, Mexican, Puerto			an, Puerto						
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id be filed a Mental Hyg arked oth atic event,	To Be	17. Father's Name (First, Middle, Last) Lynn Ulysses Moffatt 18. Mother's Name (First, Middle, Maiden Surname) Mary Muriel Porter													
id 2 shoul salth and n 27 is m er trauma		19a. Informant's Na Nadia A.			ee	19b. Mailii 1400 4	ng Address (Pond	Street and Number Ro	ber or Rura oad S	ilver Sp	City or Orin	Town, State, 2 g, Mar	ylai	nd 209	05
Page 1 ar nent of He ant: If iter ıry or oth				Removal from	Otat.	Place of Dispo cemetery, crer cropoli	natory or oth	er place)		Date 11/2010		xandri			ia
permit. Departr Imports any inju		21. Signature of Fur	neral Service Lice	enste	40 -	<u>ř</u> 44	ohald 00 Pov	Address Borg vder Mi	Ward 11 Roa	t Funera ad Belts	al H svil	lome, P. le, Ma	A ryla	and 20	705
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he Hospiti in 24 hour ne Funera pleted fille	Medical	(Check 2	: Medical Exa	hysician: To the b miner: On the bas urse Practioner:	is of examination	on and/or inves	tigation, in my	opinion, death	occurred at	the time, date ar	nd place	, and due to th	e cause		er stated.
within a company	_	29b. Signature and	title of certifier				29c. l	icense number D 60634		1		_	ed (Month, Day, Year) per 8, 2010		
		30. Name and addre	Joseph,	o completed caus	e of death (Iten	n 23a) (Type, F	Print) Mill I	Road Roo	ckvil	le, Mary	y1an	d 2085	5		
Stat Registra		31. Date filed (Monti			egistrar's Signa							_			
			- 400												

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Robert Wayne Goehringer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany WMHS Regional Medical Center Cumberland If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 X M 2 🗆 F Months Days Hours Min. Aug. 18, Year 1940 Maryland 70 Yrs Director 215-36-8451 Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State within 72 hours after death with the Maryland Director 1 X Yes 2 No Allegany Cumberland MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 USA 135 N. Mechanic St. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Armed Forces?

1 Yes 2 XNo Black, White, etc. , or þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: Specify. "natural", White 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. the Disabled Disabled alth and Mental Hygie 27 is marked other i r traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Martha J. Rodeheaver Aubra O. Goehringer .. Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11395 National Pike, Grantsville, MD Sandra L. Yoder/Sister 20a, Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State Department of I Important: If ite any injury or ot cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Country Side Crematory Oct. 26, 2010 Davidsville, PA 22. Name and Address of Facility Newman Funeral Homes, P.A. . Signature of Funeral Service Licer P.O. Box 275, Grantsville, MD 21536 X 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock or heart failure. List only one cause on each line Interval Between inset and Death Immediate Cause If inal Physician/ disease or condition resulting in death) Medical as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death 9 Unknown Unknown Records, P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2: autopsy performed? 1 Yes 2 No **Division of Vital** 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? **⊿**No Hospital Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 27. Manner / Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at iniury work? 1 ☐ Yes 2 ☐ No atural 5 Pending within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Shiv Khanna, 31. Date filed (Month, Day, Year)

28 2010

LaVale, MD

1221 National Highway,

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34594 State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 13°. 2010 Dorothy Lorraine 2:59 P. M Garv Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, 1928 D.C. 1 □ M 2🗶 F Months Days Hours 82 Director 577-32-9815 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and the file 23 a or 28a-f show ant If item 27 is marked other than "natural", or items 23a or 28a-f show my or other traumatic event, the Medical Examiner must be notitied at ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d, Inside City Limits Director D.C. 1 X Yes 2 No Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3015 Adams Street, N.E. 20018 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status Race - American Indian, Black, White, etc. Armed Forces?
1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. b 1 Never Married 2 Married Baltimore, Maryland 21215-0036 African-American 1 ☐ Yes 2 X No Specify: If Yes, Give 3X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15 Decedent's Education 16h Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing 12 Tailor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Julian Scott Lucy White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Florence P. Beckwith-Daughter 2823 Citrus Ln, Springdale, MD 20774 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 10-22-10 Brentwood, MD 4 Donation 5 Other (Specify) Lincoln Cemetery 21. Signature of uneral Service Lice e 22. Name and Address of Facility 28th St., N.E., Bonnette & Assoc. Funeral Home 20018 a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph sician/ Sepsis disease or condition resulting in death) Davs Medical Due to (or as a consequence of): Examiner Months Decubitis ulcers Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🖁 No 5 Other (specify) Month Day Year Pregnant at time of death certificate has been signed by the srector, page 2 should be detached 9 \ Unknown g Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Anemia 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Myelo Dysplastic Syndrome 24a, Was an performed 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: ည 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 X DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1X Natural 5 Pending injury after death Director: / Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie completed (Check within 2 To the I only one Signature and title of certifie 9 29c. License number 29d. Date signed (Month, Day, Year) D32332 October 18, 2010

Registrar

State

9801 Georgia

Silver 220

Ste

Ave.

0. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

P.A.

Gupta,

Suresh K.

OCT 2 0

31. Date filed (Month, Day, Year)

2010

10-08073

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<i>,</i>		5800 Coolidge Stree						Capitol Heig			la a	- 1	Prince Ge		
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D 2 should and Me T is me T and in a tice	2	19a. Informant's Name/Relation Catherine Tra			Mathar			Address (Stree Hickory					-		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: Witem 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition			20b	. Place of	Dispositi	on (Name of cer	netery,		Date	20c	Location - C		
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite	- 1	1 Burial 2 X Crema		Removal fr	rom State		ry or othe	rplace) remator		201	ember O	١,	Clint	on.	, Maryland
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buring.	sician/Me	IF FEMALE: 3b, Was decedent pregnant i past 12 months?		1 Live t	outcome of pre	egnancy 2	Feta	I death 3	Ectopic			2	3d. Date of de Month		ay Year
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Physician/ Medical Examiner and I-transit Physician: The law requires that the death certificate be executed attending physiciar Box 68760 the as use for detached P.O. sate has been sign page 2 should be Records, of Vital director, filled in by the funeral or Attending Division 24 hours after death. Funeral Director: A Hospital completed To the within 2

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permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic

hours after death with the Maryland

Maryland 21215-0036

Baltimore,

၉ 27. Manner of Death Certificate: 1 Natural ☐ Accident ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 2 f 2 29b. Signature and title of certifier Williamsport MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3H-7 32. Signature State Registrar **ORIGINAL**

10-07908 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. David Kevin Gragan State of Maryland / Department of Health and Mental Hygiene 2010 34597 Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death 1510 hrs Medical Examiner October 14, 2010 Gragan David Kevin 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore Washington Medical Center** Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY 9. Birthplace (State or **Funeral** oreign Countyaryland Months Days Hours Director 213-84-9215 48 May 26, 1962 1 X M 2 F Usual Residence of Decedent any 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No 23a or 28a-f show notified at once. MD St. Mary's Mechanicsville permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 28920 Three Notch Road USA 20695 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Oecedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married Yes 3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: White ۵ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed College (1-4 or 5+) Elementary/Secondary (0-12) MD 21215-0036 Iron Worker/Welder Steel 12 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Mary Zelda Garner Francis Gragan 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9905 Bowling Rd. Faulkner,MD Melissa Gragan/Daughter 20a. Method of Disposition

1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Mt. Rest Cemetery 10/21/10 La Plata, Maryland Donation 5 Other Specify. Signature of Funeral Service, Licensee Name and Address of Facility
AREHART-ECHOLS FUNERAL HOME, P.A. M00945 (chow ave La Plata MD 231 St Mary's Ave La Plata MD
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line en Onset and /Medical Death a Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial - transi Physician/Medical UNPENDED **AMENDED** Box 68760, 23c. If yes, outcome of pregnancy 23d, Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy 1 Live birth Fetal death Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed ficate has been si, page 2 should b 24b. Were autopsy findings available 24a Was an autopsy prior to completion of cause of certificate has performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Other₄ examiner? Inpatient 2 FR/Outpatient 3 Nursing Home 5 Residence 6 Other 1 🗸 Yes ٩ No funeral 28a. Date of Injury 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Oct 14, 2010 Subject was hit and pinned by the steel 1345 hrs Natural 1 ✓ Yes 2 No Pending the 2 🗸 Accident Investigation filled in by 28e. Place of injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) Waugh Chapel Road, Gambrills, Md. determined (Specify) construction site 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 15, 2010 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) . Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ October 199, 2010 William P. Gillogly 7:50 \mathbf{a}^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 112 Circle Ave. Indian Head Charles Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Yea 9. Birthplace (State or Foreign Year) - 1931 Days 1**X** M 2 □ F Massachusetts Director 023-22-4989 Dec. Usual Residence of Decedent 28a-f shov per it. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho amy injury or other traumatite event, the Medic at Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 XNo Maryland Charles Bryans Road 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2157 Crest Circle 20616 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Electrician D.C. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William C. Gillogly Mildred B. McDonnell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sister Mildred H. Raby 112 Circle Ave., Indian Head, Md. 20640 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Indian Head, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Charles Cemetery Signature of Funeral S 22. Name and Address of Facility
Williams Funeral Home, P.A. M00668 4270 Hawthorne Rd., Indian Head, Md 20640 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slure. List only one cause on each line. 23a. Part 1. Enter the shock, or heart Interval Between Immediate Cause Fi disease or condition resulting in death) Final Onset and Death Physician/ Medical Examiner ORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exam that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p I for use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown signed by the atte 4 ☐ Pregnant at time of death 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Hospital or Attending Physician; The law requires 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perforr death? 1 Yes 2 No Yes 2 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Sisters Residence 2 **X** No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 Yes within 24 hours after death.

To the Funeral Director: A
completed filled in by the fu 2 No 2 Accident
3 Sulcide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Configure Nurse Exactioner 1. The past of my knowledge of all received at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29c. License number 3885 W 2010

Registrar DHMH 17 Rev 7/2009

Box 68760

P.O.

Division of Vital

50

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMANAN

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month CTOBER 2010 KAREN LYNN 11:11 PM GREEN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthdav) 8 Date of Birth 9. Birthplace (State or Foreign 6 Sex Funeral Days Hours 1 □ M 2 □ X F 53 011/24/11/95/7 Marvland Director 216-70-0088 Usual Residence of Decedent show er than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 🌠 Yes 2 □ No MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 116 Pine Avenue 21701 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: white 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit, Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Frederick County Elementary/Seconday (0-12) College (1-4 or 5+) Government housing coordinator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Robert James McHugh Emma Jane Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John R. Green, Sr./ spouse 116 Pine Ave., Frederick, MD 21701 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Zion UM Cemetery 11/01/2010 Myersville, MD Mt. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Keeney & Basford Funeral Home Bullekleh MO1222 106 E. Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Cardio Pulmonary disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death 1 Yes 2 I g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No 1 🗌 Yes Certificate: To 1 Inpatient 2 Z ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred To the Funeral Director; After completed filled in by the funer Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral D To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Get thy projection to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier D 604 MD

10

DHMH 17 Rev 7/2009

State Registrar Frederick imp 21702

-C Thomas

32. Registra s Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hemen Shah

31. Date filed (Month, Day, Year)

Cailin Roberta G		borough State of M	aryland / Depa <i>Cei</i>	artment of rtificate of		d Mental H		201	0 34600				
Physicia Medical Exami	an/	1. Decedent's Name (First, Middle,Last) CAILIN ROBERTA (COLDSBORO	UGH			2. Date of Deat Month October 24	Day Year	3. Time of Death 0000 hrs				
		4a. Facility Name (if not institution, give street 5 Garrett Avenue	and number)	4b. City, Town, or Location of Death La Plata			1	4c. County of Charles	Death				
Funeral Director		5. Social Security Number 6. Sex 214-89-636 1 M 2	7. Age (In yrs. I	ast birthday) Yrs	If Under 1 Year Months Day			1	9. Birthplace (State or Foreign Country) MD				
A		Usual Residence of Decedent				<u></u>	13 21	2010	10d. Inside City Limits				
d how any		10a. State 10b. County CHARLES	Tuc. City,	Town or Locat	ALDORF				1 Yes 2 No				
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number			10f. Zip Code		10	Og. Citizen of Wha	t Country?				
ith the days or notified	ral Dir	2117 GIBBONS COU		6 142 W	206		acifu Vas ar No	U.S.A	• American Indian, Black,				
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.	Fune		/as Decedent Ever in U. rmed Forces? Yes 2 No Give Year			<pre>spanic Origin? (Sp , Mexican, Puerto specify:</pre>		White,					
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15-0036 filed within 7. I Hygiene. ed other than 1, the Medical	S	17. Father's Name (First, Middle, Last)	Policii	l		1B.Mother's Name		·					
2121 ould be fi I Mental J s marked	To Be	MATTHEW GOLDSBO 19a. Informant's Name/Relationship (Type, Pr		19b. Mailing	Address (Stree			RGINIA I					
MD and 2 sho saith and 27 is		MATTHEW GOLDSBOR	20h I	Disco of Discos	ition (Name of cor	netery	WALI	OORF , MD 20c. Location - C	20602				
imore, Pages 1 a nent of He ant: If ite		1 Burial 2 Cremation 3 Rer Donation 5 Other Specify:	noval from State	ITY ME	ner place) M • GARDE	NS 10-		WALDORI					
Baltin permit. Departm Importa		21. Signature of Funeral Service Licensee	, M00479	I R.	lame and Address AYMOND	FUNERAL	SERVI	CE,P.A					
Physician		23a. Part I. Enter the disease, or complication failure. List only one cause on each line.						est, shock, or hear	Between Onset and				
/Medical Examiner			dden Unexp		Death In	Infancy	(SUDI)		Death				
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	(or as a consequence o	f):									
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	ı≊i	IF FEMALE: 23c. 1 past 12 months?	If yes, outcome of preg		tal death 3	Ectopic pregna	ancy	23d. Date of d Month	elivery Day Year				
30x 6 death ce e attend I for use	. <u> </u>	1 Yes 2 No 9 Unknown 9	Pregnant at time of de	eath 5 Ot	her (Specify)				L.				
P.O. Es that the es that the igned by the detached	by Phy	Part II. Other significant conditions contrib	outing to death but not re	esulting in the u	inderlying cause o	iven in Part I.	23e. Did to		ute to the cause of death? Probably 4 Unknown				
ds, Fequires 1	eted t						24a. Was a	an 24b. W	ere autopsy findings available				
Division of Vital Records, at a or Attending Physician: The law requires after death. The retrievant from this certificate has been sind the funeral director, page 2 should be in by the funeral director, page 2 should be	omple						autop perfor 1 ✓ Yes	med? de	or to completion of cause of ath? ✓ Yes 2 No				
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The state of the s									or Rural Route Number, City				
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate vithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b	ပြ	4 Homicide Certifying Physician: To one) 2 Medical Examiner: On the	the best of my knowled	ge, death occur	red at the time, da		due to the caus	e(s) and manner a	s stated.				
To t with To t	Medical		anner stated.		29c. Licens	e number			(Month, Day, Year)				
		Theodore M.	Kind JR.	in.)	O.C.I	M.E. (DCME	October 25,	2010				
	Ì	30. Name and address of person who completed Theodore M. King, Jr., MD. A	ed cause of death (Item ssistant Medical E		111 Penn Str	reet, Baltimor	e, MD 21201						
		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ire A. As	all								
Regist	nen	MUANTATOLO	Jak Jakobar	6									

			For State	State o	of Maryla	•	artment of I tificate of I		nd Menta		ene 3. No 2 0	10	34601
			Registrar 1. Decedent's Name (First, Middle	, Last)		007	inoute or i	Journ		e of Death		1 0	3. Time of Death
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	Examin		4a. Facility Name (if not institution,		nber)		4b. City, Town, o	r Location of D	Death		4c. County	of Death	
غام م			Southern Maryl	and Hosp	tal		Clinton		The Lee	(D)	Prin	ce Ge	
	Funeral Director		5. Social Security Number 404-56-6314	6. Sex 1 M 2 X F	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours		e of Birth onth, Day, Ye 18/19	ear)	9. Birthp Count Germ	
			Usual Residence of Decedent		- 80				1.10	/10/1	,		
	fand f shov	to	10a. State 10b. County		10c. (City, Town or Lo	cation					1	0d. Inside City Limits
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	th the 3a or the n		10e. Street and Number) C M DD			10f. Zip Code 20744				g. Citizen of ' USA	What Coun	itry?
	12205 Firth Of Tae DR 20744 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P									or No-	14. Race - American Indian,		
0	ter de or ite	by F	1 Never Married 2 K Man		2 🔀 No		f Yes, specify Cuba I ☐ Yes 2 🛣 No		Puerto Rican, e	etc.)		ck, White, e	etc.
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5	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 🛣 Burial 2 □ Cremation		n State	cemetery, crer	natory or other pla					•	
Dallimo	nit. Pa artme ortani injury		4 ☐ Donation 5 ☐ Other (S 21. Signature of Funeral Service)				rs Cemeto 2. Name and Addre						ry, wv
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5	that the	y P	Part II. Other significant condition	ons contributing to	death but not	resulting in the t	underlying cause g	iven in Part I.	23	Be. Did toba	icco use con	tribute to th	ne cause of death?
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ě	The la ante ha page	Com							1	perform	ed/?	death?	2 No
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DIVISION OT	Atter er dea ector by the	Certificate:	3 Suicide 6 Could 4 Homicide detern	not be 28e, Plac	e of Injury - At	t home, farm, str	eet, factory, office			cation (Stre		per or Rura	Route Number,
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	o the	Σ	only one) 3 L Certifying 29b. Signature and title of certifie	Nurse Practioner									5 14 1
	10		MSil				DO	157 EJ			10-1.	3- 2	00
	, , ,		30. Name and address of person	who completed cau	use of death (I	tem 23a) (Type, I	29c. Licens O y Print) OS for 1J	// -	_	, 1	Ma	7	7(.,
			1	MOW / MAN). 117	no/ (ivi	95 to 17	#101,	tt CVA.	pyte		101	X4
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State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Day Year **Physician** October 19, 2010 9:30 a Rosemerie Corrado Hauft /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Brooke Grove Nursing Home Sandy Spring | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Manch 9, March 9, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🖺 F Yrs. 579-38-7985 91 Kentucky Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c, City, Town or Location 28a-f show Examiner must be notified at 1 Yes 2 No Montgomery Kensington Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 0 USA 3801 Archer Place 20895 or Items 23a Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Specify. White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. 2 3

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□ Divorced Year or Dates: "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) than College (1-4or 5+) Homemaker Own Home other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be s 1 and 2 should be fi f Health and Mental H fem 27 is marked ot other traumatic ever Michael J. Corrado Armida Volponi ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2:
Department of Health ar
Important: If frem 27 is
any injury or other trau Richard V. Hauft/Son 17717 Little Haven Lane, Olney, MD 20832 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Oct. 22 1 Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2010 Silver Spring, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. any 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** months Uterine Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, and immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit attending physician and Due to (or as a consequence of) Hospital or Attanding Physician: The law requires that the death certificate be exe Box 68760. Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 5 ☐ Other (specify) be detached 1 ☐ Yes 2X No Division of Vital Records, P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 🗆 No 3 ☐ Probably 4 SUnknown 1 Tyes Hypertensian, Cholesterol, Deep Venous Thrombosis, Low Albumin been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? has page 2 certificate 1 ☐ Yes 2₩ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 X Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 🗌 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier edicai pletely (Check only one) and manner stated within 2 29d. Date signed (Month, Day, Year) 29b. Signature #d title of certifie 29c. License number 2 D57630 October 19, 2010 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person what Anuracha Arun, MD 10301 Georgia Avenue, #209, Silver Spring, MD 20902 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiege 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** *tunter* 138 p CLAYTON ATTHEW 2010 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMER SHADY GROVE ADVENTIST OCKVILLE Date of Birth (Month, Day, Year) If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 M 2 ☐ F Months Days Hours Min. Yrs NONE MARYLAND Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10h. County 10d. Inside City Limits 28a-f show must be notified at 1 Tes 2 No Director Rockville Maryland Montgomery 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neary Injury or other traumath." 20850 U.S.A. 9901 Medical Center Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ■ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 ■ No Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Infant Infant 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna W. Miriam Hunter ပ Alan K. Hunter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10120 Durango Drive, Damascus, Maryland 20872 Anna W. Hunter/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Oct 13,2010 Alexandria, Virginia Crematorium Inc. 22. Name and Address of Facility Molesworth—Williams, P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, EXTREME PREMATURITU **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence or) tany, leaving to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and s the burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav Year 5 Other (specify) signed by the a 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 TYes 3 Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform ate 1 ☐ Yes 2 ☐ No 1∐ Yes certific 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient ၉ 2 ER/Outpatient 3 □ DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No 6 Could not be

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Director: within 24 hours after
To the Funeral Direcompletely filled in by hours after

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
> KALPANA ITELM BRECHT, 9901 32. Registrar's Signature 31. Date filed (Month, Day, Year)

determined

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

MEDICAL CENTER DRIVE,

🔀 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

59166

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Medical

State Registrar

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death oct. 2010 Physician/ 8, 1341 Leon R. Hawkins Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Takoma Park Adventist Hospital 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Sept. 12,1934Washington DC 1 KM 2 - F Hours Min Director 577-40**-**3967 7.6 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1★ Yes 2 No DC Washington, D. C. 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20017 12th 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 V Yes 2 No. 29/53 If Yes, Give 1/29/54 Year or Dates 2/11/54 Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: 3 Widowed 4 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Automobile Salesman Private 12th. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Doris Harrod Leon Hawkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20003 1100 First Street, S.E. Wash. DC <u>Jennifer Hawkins/Daughter</u> 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Dateukn cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Triangle, Virginia Quantico National 4 ☐ Donation 5 ☐ Other (Specify) Funeral Home 22. Name and Address of Facility Latiney's 21. Signature of Funeral Service Licensee 3831 Georgia Ave., NW Wash. D.C. 20011 cc0278 Part 1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ardionspira disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Show Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed ansmous the burial-tran the attending physician and that initiated events Due to (s a consequence of) resulting in death) Last Physician/Medical phon cascular Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Month Pregnant at time of death 2 No Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has Acute 2 1 ☐ Yes 2 ☐ No After this certificate 26. Place of Death (Check only one) 25. Was case referred to medica Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 No 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral directors. 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) of certifier 29b. Signature and

Registrar

State

31. Date filed (Month, Day, Year)

4701 Randolph Ed #216. ROCKNIG, MD 20852

Name and address of person who completed cause of death (Item 23a) (Type, Print)

37. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ottober 17, 2010 11:00A. M Donald F. Holloway Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Silver Spring 3152 Gracefield Road, MS#111 . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours Aug. 22, 1916 Brooklyn, NY 1 🕅 M 2 🗆 F 94 350-16-7110 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State Director 1 Yes 2 No Silver Spring Maryland Prince George's 10f. Zip Code 10e, Street and Number 10g, Citizen of What Country? Funeral 3152 Gracefield Road, MS#111 20904 United States 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No If Yes, Give Black White etc "natural", or 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 ☐ Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical E 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Tanning Industry Chemist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Ethel Lillian Hagerstrom Francis Joseph Holloway 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11707 Magruder Lane Rockville, Maryland 20852 Jean H. Milstein -daughter 20a. Method of Disposition
1 □ Burial 2 X Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Metropolitan Crematory 10/18/2010 Alexandria, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Bonala Modes Borgwardt Funeral Home, PA V. Bar 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Concestive Heart Failure disease or condition Medical resulting in death) Examiner Coronary Artery Disease Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examir Hypertension and -tran that initiated events Due to (or as a consequence of) resulting in death) Last physician the burial Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death by the detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed be should be det þ Anemia Hospital or Attending Physician: The law requires 24 hours after death.
Funeral Director: After this certificate has been sign Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 perform Yes 2 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify, filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🔼 Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours a Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 ho To the Fune completed fi (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) D57284 October 18, 2010 nau 10

31. Date filed (Mont) 1 9 2010 Registrar

Anna Korzan, M.D.

egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3110 Gracefield Road Silver Spring, Maryland 20904

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 17, Day 2010 11:00 a Elia Isabel Hernandez Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** July 8, 1933 1 □ M 2 🛂 F Months Days Hours Min. El Salvador Director 77 None Usual Residence of Decedent r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location with the Maryland 10d. Inside City Limits Director 1 Yes 2 No MD P.G. Hyattsville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 8121 20th Avenue 20783 El Salvador hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 X Yes 2 ☐ No Specify: Salvadorean Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 π and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Emilio Hernandez Lauriana Aragon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Arelis Isabel Velasquez/Daughter 8121 20th Avenue, Hyattsville, MD 20783 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 1 😾 Burial 2 🗌 Cremation 3 🖈 Removal from State Cementerio General de Pasacuina Pasaguina, La Union, 2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses ²Francis Addres Cofficins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failule. List only one cause on each line Immediate Cause (Final Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir The law requires that the death certificate be executed Cause (Disease or iinjury sician and burial-tran that initiated events resulting in death) Last Due to (or as a cor attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: es, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death the Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Junknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 **X**No မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 1 🛛 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29b. Signature and title of cartifier 29c. License numbe 29d. Date signed (Month, Day, Year)

State Registrar

3

Registrar's Signatu

7600 Carroll Avenue, Takoma Park, MD 20912

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Padma Chirumamilla, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State of Maryland / D	Certificate of E		, ,	g. No 2010	34607			
	Physicia Medic		Decedent's Name (First, Middle, Last) LINA MAE HARR	IS		2. Date of Death	Pay Sear	3. Time of Death			
	Examir		4a. Facility Name (if not institution, give street and number) DOCTOR'S HOSPITAL	4b. City, Town, or LANHAM	r Location of Death		4c. County of Deat	h			
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho		If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, Y	9. Bin	thplace (State or Foreign			
	and show at	ŏ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of the county								
	Maryla 28a-f otified	irect		ELLVILLE				1 🄀 Yes 2 □ No			
	ith the 23a or st be n	Funeral Director	100. Street and Number	10f. Zip Code	721		g. Citizen of What Co	untry?			
õ	within /2 hours after death with the Mayland gjene. et than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by Fune	1806 WAESCHE COURT 11. Marital Status 1 Never Married 2 Married	13. Was Decedent of Hi If Yes, specify Cubar	Vas Decedent of Hispanic Origin? (Specify Yes or No Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes 2 X No Specify:			rican Indian, e, etc. LACK			
215-0036	nours a	eted	3 Widowed 4 Divorced If Yes, Give Year or Dates. 15. Decedent's Education 16a D	1 ∐ Yes 2 Lou No Decedent's Usual Occupa							
<u>ლ</u>	hin 72 h ne. than "n ie Medi	Completed by	(Specify only highest grade completed) ((Give kind of work done d fe. DO NOT use retired)	during most of wor	king	16b. Kind of Business Industry				
2	filed withii tal Hygiene d other th event, the	Be	6TH 17. Father's Name (First, Middle, Last)	HOUSEWIFE	18. Mother's Nan	ne (First, Middle, Ma	PRIVATE iden Surname)				
yland		2	HUEY PAYNE		SARAH	LEACH					
, Mar	1 and 2 should be f Health and Men item 27 is marke other traumatic	19a. Informant's Name/Relationship (Type, Print) DOROTHY JACKSON/DGT. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 1806 WAESCHE COURT MITCHELLVILLE, MARYLAN									
nore	ge :±or		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Place of □ cemetery, NEW PRO	Disposition (Name of crematory or other place	סויונט י		cation - City or Town, State				
baltimo	permit. Par Departmer Important any injury once.		21. Signature of Funeral Service Licensee	22. Name and Addres	ss of Facility J.	B. JENKI	NS FUNERAL	L HOME, INC.			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	7474 T.ANDO t enter the mode of dying	OVER ROAD g, such as cardiac	HYATTSVI or respiratory arrest	LLE, MARYL	AND 20785 Approximate			
1	hysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	e cerebro	Vascu	lan Di	Sector	AND 20/85 Approximate Interval Between Onset and Death Service Servic			
	Examiner	L	Distriction (or as a consequence of):	enotic	Cond	io Vanc	way Disa	lest Weller			
-	ed sit	mine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	(5000			9.00			
	execution and arrial-tran	al Exa	that initiated events c. The properties of the	DI.	stur			years			
20	cate be physic s the bu	edica	d					<u>.</u>			
סס אחם	To the hospital or Attending Prysician: The law requires that the death certificate be executed within 24 hours after death, after this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant	3 Ectopic pregnancy 5 Other (specify)	у		23d. Date of deli Month	very Day Year			
5	that the ned by e detacl	by Ph	Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause give	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?			
cords,	equires een sig nould b	eted !				1 🗆 Yes	2 No 3 □ Pr	obably 4 🗆 Unknown			
ביי	The law rate has b	Completed				24a. Was an autopsy performe	prior to death?	opsy findings available ompletion of cause of			
9	ician: certifica ector, p	BB	25. Was case referred to medical examiner? Hospital:		ace of Death (Chec		VNO TE les	2 🗆 110			
5	g Pnys er this eral dir	e: To	27. Manner of Death 28a. Date of injury 28b. Tim	ne of 28c. Injury	4 ∐ Nursing Ho	ome 5 Residence 28d. Describe how	se 6 Other (Speci	fy)			
	death.	Certificate:	1 Natural 5 ☐ Pending (Month, Day, Year) inju 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	M 1 🗆 Y	? Yes 2□No						
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	tne nost nin 24 ho the Fune npleted f	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge, dea only one) 3 Certifying Nurse Practioner: To the best of my knowled	vestigation, in my opinion	n, death occurred a	t the time, date and p	place, and due to the c	ause(s) and manner stated.			
	vitt To		29b. Signature and with of certifier. Kake and M	29c. License	20 C	8 29d	Date signed (Month)	Day, Year)			
_	/		29b. Signature and title of certifier X	e, Print) antfox (a)	ne, Sui t	, 222, Be	WIE, MD,	20715			
	State Registra	_	31. Date filed (Month, Day, Year) 32. Registrars Signature	1	7122		-/				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death ^{Day} 25 2010 Physician JOSEPH HICKS CLINTON OCTOBER 11:02A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHARLES 8595 FAIRGROUNDS ROAD BEL ALTON 8. Date of Birth 9-2-1940 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1**√** M 2□ F MD . 214-42-4233 70 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location or 28a-f show notified at 10d. Inside City Limits 10b. County MD. CHARLES BEL ALTON 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or 7 8595 FAIRGROUNDS ROAD 20611 U.S.A. Funeral death ral", or items 2 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian be filed within 72 hours after intal Hygiene. 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates: 1 Never Married Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specif BLACK Š 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation traumatic event, the Medical 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) C.BROOKS MASONARY MASON 9th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental F THOMAS WHALEN ပ MADELINE HICKS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: If item 27 is any injury or other traionce. MARGARET HICKS-SPOUSE 3402 ALTO RD. BALTIMORE, MD. 21216 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from METROPOLITAN CREMATORY 11-2-10 ALEX., VA. 4 □ Donation 5 □ Other (Specify) 2. Name and Address of Facility RAYMOND FUNL SERVICE, P.A. 5635 WASHINGTON AVE., LA PLATA, MD 20646 21. Signature of Funeral Service Licensee M00479 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death arruthmia Cardiac Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed g physician and Due to (or as a consequence Box 68760, Physician/Medical as attending | for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy this certificate 1□ Yes 2 1 funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 2 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: Injury at Work? Natural 5 Pending Injury death. investigation 1 ☐ Yes 2 ☐ No spital or Attendi nours after death. Ineral Director: A y filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 0.261029b. Signature and title of certifier

DHMH 17 Rev 1/2001

State

Registrar

11637

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Janwala

2010 ▶

lanisha

Year)

31. Date filed (Month, Day,

MD

Rysecra

32. Registrar's Signature

D0057999

Terrace Prive Ste 103 Waldof, MD 20602

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

oniey rian		I-For State Criticate of Death			34609
Physicia edical Examin	n/	Registrar 1. Decedent's Name (First, Middle, Last) Geoffrey Lee Hall	Date of Death Month	n Day Year	3. Time of Death 0356 hrs
Suicai Examin		4a. Facility Name (if not institution, give street and number) Harford Memorial Hospital 4b. City, Town, or Location of De Havre de Grace	October 15	4c. County of Deat	
Funeral Director		217-25-0352 1XM 2 F 21 Yrs.	Hrs. 8. Date of Birth Min. 04-25-	Forei	rthplace (State or gn gn yountr)() Aryland
Varyland 28a-f show any 1 at once.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Harford Havre de Grace			10d. Inside City Limits 1 Yes 2 No
th the Maryland 23a or 28a-f sho	Director	10e. Street and Number 40 Robinhood Road Box 759 21078		g. Citizen of What Cou uted State	untry? sof America
er death wi	- T	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year or Dates: 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 1 Yes, Specify Cuban, Mexican, Pue 1 Yes 2 X No specify:		White, etc.	rican Indian, Black,
U36 thin 72 hours ne. than "natur- ledical Exami	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Traffic Flagger		16b. Kind of Business. Transport	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "; injury or other traumatic event, the Medical E	Be	Robert William Hall, Sr. Debora	ame (First, Middle, M h Price		T- 0-10 01076
and 2 shoul and 2 shoul fealth and M frem 27 is m fraumatic		Deborah Hall (mother) 40 Robinhood Rd Box 7 20a. Method of Disposition (Name of cemetery,	759, Havre	de Grace, Ma	ryland
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite injury or other tr		4 Donation 5 Other Specify:			r,Pennsylva P.A. 2107
Charte Balt Mark Depart Import Import Injury	+	21. Signature of Feneral Service Libenses 22. Name and Address of Facility 7 123 S Washington 23a. Part I. Enteraire disease, or complications that caused the death. Do not enter the mode of dying, such as cardia			Approximate Interval
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Methadone Intoxication Due to (or as a consequence of):			Between Onset and Death
	튑	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that imitiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):			
e executed cian and rial - trans	Medical E	d. ☐ AMENDED 23a,27,28a-f per me g909 11	-10-10 vt		
		IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	gnancy	23d. Date of deliver Month	y Day Year
es that the de signed by the se detached fi	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		pacco use contribute to	the cause of death?
He law requirate has been age 2 should	Completed		24a. Was ar autops perform 1 V Yes 2	y prior to ned? death?	utopsy findings available completion of cause of es 2 No
VITAI KEC ysician: The l his certificate l director, page	Be l	25. Was case referred to medical examiner? 1 Vers 2 No No Cher4 Number Cher4 Number Cher4 Number Number Ch			
tending Phy eath. cor: After th		27. Manner of Death Natural Accident New Yes 2 No 28a. Date of Injury (Month, Day, Year) Accident Notice 1 Pending Investigation The property of the pending Investigation Investigation Investigation Notice 2 No 28b. Time of Injury 28c. Injury at Work? The pending Investigation Investigat	28d. Describe ho	ow injury occurred	
To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification	3 Suicide 6 X Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) found in house	28f. Location (St or Town, Sta Havre d	reet and Number or Robin e Grace, M	ural Route Number, City nwood Rd. aryland
To the Ho within 24 I To the Fu completely	edica	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. 29b. Signature and title of oertifier 29c. License number			ne cause(s)
		0.C.M.E.		October 15, 201	
		30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore,	MD 21201		
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV. 0.4. 2010 Registrar's A. Maries			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Marylar				∕lental Hy	giene	2010	34610
			_ State Registrar		Cer	tificate of L	Death		Reg. No	2010	34010
P	hysicia		1. Decedent's Name (First, Middle, Las GRACE LILLIAN JOH	,				2. Date of De Month 3/		y Year	3. Time of Death 0128 M
	Medic Examin		4a. Facility Name (if not institution, give	street and number)		4b. City, Town, or	Location of Death	1-0/ -0/		County of Deat	
			Holy Cross Hospit			Silver S			Mo	ontgome	ry
	uneral irector		5. Social Security Number 6. S	□M 2XTE	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 02/27/	th y, Year)		thplace (State or Foreign untry)
- 47			065-14-4526 Usual Residence of Decedent	90				102/21/	1920		NC
/land	f shored at	tor	10a. State 10b. County	10c. Ci	ity, Town or Lo	cation					10d. Inside City Limits
Man	28a-	irec	MD Montgome:	ry Sil	ver Spi						1 🖾 Yes 2 □ No
ith the	3a or t be r	ral	10e. Street and Number 2301 Glenallen Av	75nus #320		10f. Zip Code 20906				izen of What Co	ountry?
ath w	r mus	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.	.S. 13. V		spanic Origin? (Spe	ecify Yes or No-	USZ	14. Race - Ame	rican Indian
ter de	, or it	by F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🖾 No		Vas Decedent of Hi f Yes, specify Cuba □ Yes 2 🛣 No		Rican, etc.)		Black, White	
ZIZIO-UUSO within 72 hours after giene.	tural" al Exa	ted	3 Widowed 4 X Divorced	If Yes, Give Year or Dates.							ack:
72 hc	n "na Aedic	Completed	15. Decedent's E (Specify only highest gra	ade completed)	(Give I	lent's Usual Occupa kind of work done o O NOT use retired)		ing	î .	ind of Business	Industry f Columbia
within viene.	er tha		Elementary/Seconday (0-12)	6 College (1-4 or 5+)	Educa					lic Sch	
yland ylabe filed Mental Hy	d oth event	To Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam			Surname)	
Men be	narke		Warren Coleman				Beulah V				
Man 2 sho Ith and	27 is r traur		19a. Informant's Name/Relationship (To Warida M. Johnson-	_		g Address (Street a			-		o Code) , MD 20902
1 and Fea	item		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of		Date		ocation - City or	
Page Percent c	ant: If Iry or		1 ☐ Burial 2 🛛 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State Ar	_ /'1	natory or other place		L5/10	Har	nover, i	MID
Daltinore, bermit. Page 1 and Department of Hea	Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signat Funeral Service Licens		-/-	. Name and Addres				ral Home	
20	_ E # 5		- inge	1 June		6 N. Was				le, MD	20850
			23a. Part 1. Enter the disease or comp shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line.			g, such as cardiac o	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	sician/ edical		disease or condition resulting in death)	a. Shortness Due to (or as a conseq		ath					Onset and Death
Exa	miner			Hematuria	quence oi).						
	0-	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of):						
cuted	P _a	xam	Cause (Disease or injury that initiated events	c. Sepsis Due to (or as a conseq							
эе ехе	ician a	dical Examiner	resulting in death) Last	. Stroke	juence oi).						
icate b	g phys is the	1edic		d							
certifica	ending use a		200. Was decedent pregnant	23c. If yes, outcome of pregna		Ectopic pregnanc	M.		1	23d. Date of del	livery
death	the att	/sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of 9 Unknown		Other (specify)	,			Month	Day Year
igt the	ed by 1 detach		Part II. Other significant conditions of	ontributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.	23e, Did to	obacco us	se contribute to	the cause of death?
Jires t	signe Id be	d by	Dehydration					1 🗆	Yes 2	Ç No 3□Pı	robably 4 🗆 Unknown
ecorus,	s beer shou	plete	Acute renal fa	ilure				24a. Was			topsy findings available
The lay	ate ha	Completed					_	autor perfo	osy irmęd? 2 🔯 No		completion of cause of
VILCIII.	ertifica ector, 1		25. Was case referred to medical examiner?	Uponitali		7	ce of Death (Check			1000	W. 1078447007 100
Physi	this c	요 .	1 ☐ Yes 2 🔀No 27. Manner of Death	Hospital: 1 M npatient 2 28a. Date of injury	ER/Outpatien 28b. Time of		4 L Nursing Ho				ify)
ding P	After	Certificate:	1 X Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	28c. Injury work' M 1 🔲	Yes 2 No	28d. Describe h	iow injury	occurred	
Atter	ector by th	ertifi	3 Suicide 6 Could not be 4 Homicide determined		ome, farm, stre	et, factory, office				Number or Ru	ral Route Number,
ital or	ral D	S a		building, etc. (Specin)	y) 			City or Tow	(n, State)		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours are death.	Fune eted fii	Medical	(Check 2 Medical Exami	sician: To the best of my knowner: On the basis of examination	n and/or investi	igation, in my opinio	n, death occurred at	the time, date a	nd place,	and due to the	cause(s) and manner stated.
To the within	To the	Σ	only one) 3 L Certifying Nurs 29b. Signature and title of certifier	e Practioner: To the best of m	іу кпоміваде, а	29c. License				e signed (Month	
	10		Kenama	ang		D60826	5		10/	/13/2010)
			30. Name and address of person who c					0007.5			
			Kshama Garg, 150 31. Date filed (Month, Day, Year)	0 Forest Glen			pring, MD	20910			
R	Stat Registra	~	OCT 20 201	3. Registrar's Signa	. fran	Ked					

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Tammy Marie Je		y in the state of									
		1- For State Registrar 1. Decedent's Name (First, Middle,I	t\	Cei	rtificate of l	Death		2. Date of Dea	eg. No.	3 4 5 1 1	
Physicia Medical Examin			Tammy Mar	ie Jes	see			Month October 1	Day Year 1, 2010		
		4a. Facility Name (if not institution,	give street and num		4b	• • • • • • • • • • • • • • • • • • • •	or Location of I	Death	4c. County o		
	Ц	Route 40 West of Churc		. Age (In yrs. I		Myersville If Under 1 Ye	as I lé l la das é	MUss IS Date of Bi	Frederic	9. Birthplace (State or	
Funeral Director						Months Da		Min.		Foreign	
		218-72-3850 1 Usual Residence of Decedent	M 2XF	50	115.			Nov.18	1959	Country Maryland	
v any		10a. State 10b. County		10c. City,	Town or Location	n			10d. Inside 0		
land -f shov	ξ	Maryland Washi	ngton			ig Poo				1 Yes 2 No	
e Mary or 28a	Director	10e. Street and Number				10f. Zip Code		1	10g. Citizen of What Country?		
s 23a e notif		12821 Keefer Ro	ad 12. Was Deced	dent Ever in U	.S. 13. Was	Decedent of H	21711 Iispanic Origin	? (Specify Yes or No		S . A	
death y	Funeral	1 X Never Married 2 Marr	ed Armed Ford	ces? 2 X No				uerto Rican, etc.)	White	, etc.	
after	by F		ed If Yes, Give Year or Dates:			es 2 📉 N			Specify:	White	
2 hours		15. Decedent's Education (Specify Elementary/Secondary (0-12)	only highest grade		16a. Decedent's during mos		ation (Give kin e. DO NOT us		16b. Kind of Bus	siness/Industry	
036 thin 7, ne.	Completed	12	00090(1	. 0, 0 . ,		Mana	l Service				
5-0 iled wi Hygier I other		17. Father's Name (First, Middle, La	ist)					Name (First, Middle, I	Maiden Surname)		
121 Id be f Aental narked event,	o Be	Robe 19a. Informant's Name/Relationship	rt Nelson	Jesse		ddraes (Str	not and Numbe	Ada Ire		on Jessee	
AD 2 show h and h and l matic	-	Steven W. Jesse				Big Pool,		•			
re, F 1 and F Healt f item		20a, Method of Disposition 1 Burial 2 X Cremation		20b. I	Place of Disposition	on (Name of c		Date		City or Town, State	
Pages Pages nent of		4 Donation Other Spec		1	Smithsbu Cremator	า์ iim	(Oct.14,201	0 Smiths	sburg, Maryland	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Section Lie	ense	ss of Facility Win Tho	ompson Fun	eral Hom	ne, Inc.				
Physician		23a. Part 1 Enter the disease, of co		sed the death	1 136 Do not enter the	mode of dying	ional l g, such as card	lac or respiratory arr	r Spring est, shock, or hea	rt Approximate interval	
Examiner		failure. List only one cause on Immediate Cause (Final disease	a. Multiple Injur	ies						Between Onset and Death	
Exammer		or condition resulting in death)	Due to (or as a co	onsequence o	f):						
	필	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co	onsequence o	f):					_	
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a co	onsequence o	n:						
		events resulting in death) case									
), be exe sician s urial -	ğ	UNPENDED	AMENDED								
Box 68760, e death certificate be the attending physical for use as the burst		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, ou			death 3	Ectopic pr	regnancy	23d. Date of o	delivery Day Year	
ox 6 strength cert	' i	past 12 months? 1 Yes 2 No 9 V Unkno		nt at time of de	-41-	(Specify)					
b. BC the de	Physi	Part II. Other significant condition	3 Olikiow		esulting in the unc	lerlying cause	given in Part I	23e. Did to	bacco use contrib	oute to the cause of death?	
P.O. es that the igned by be detach	盃		•			, , ,			2 No 3	Probably 4 Unknown	
rds, requir	ompleted					-		24a. Was autop		ere autopsy findings available for to completion of cause of	
Reco	E O								med? de	eath? ✓ Yes 2 No	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Be C	25. Was case referred to medical examiner?	[Hospital: 4] Inc				e of Death (Ch				
of Viting Physical After this	리	1 Yes 2 No 27. Manner of Death	, ,b		ER/Outpatient 3		Other ₄ N		Residence 6 🗸		
Division of 'ppiral or Attending Phours after death.	ertification:	1 Natural 5 Pending		ay Year)	1606 hrs	1	Yes 2 No	Driver auto			
Division al or Attendi rs after death. al Director: A	iii ca	2 Accident Investig 3 Suicide 6 Could n	ot be 28e. Place of	of Injury - At ho	ome, farm, street,	factory, office	building, etc.	28f. Location (S or Town, S		r or Rural Route Number, City	
Dispital spital hours a neral]	O	4 Homicide determine 29a. Certifier A Contifuing Physics	1-777	Major Road				Route 40 Wes	st of Church Hill	Road, Myersville, MD	
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical	(Check only Certifying Fifys	ner: On the basis of	examination a				and due to the caus red at the time, date			
To with	Me	29b. Signature and title of certifier	and manner stat	ted.		29c. Licen	se number		29d. Date signe	d (Month, Day, Year)	
		Curso.				0.0	.M.E.		October 12,	2010	
		30. Name and address of person wh			^{23a)} 111 Penn Str	not Baltim	ore MD 24	201			
5	ate	Ana Rubio MD. Assisi	tant Medical Ex	strar's Signatu		set, Dalum	ole, IVID 21				
Pogist		UUI"ID	WIN LE	CAS AS DO	1. Litte	and the same					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **VIRGINIA** JORDAN 2010 8:59 P Ĭ4, October 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 4974 Thomas Long Road Crisfield Somerset If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 1 □ M 2 🛂 F Month, Day, Year) December 5, 1922. Months Days Hours 87 Yrs. 154-20-4535 New York Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 No Maryland Somerset Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4974 Thomas Long Road 21817 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wynant C. Farr Marie Opie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4974 Thomas Long Road - Crisfield, MD 21817 Vincent Jordan (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Crematory of Delmarva Oct.16,2010 Delmar, Delaware 4 □ Donation 5 □ Other (Specify) 21. Situation of FundayService license. Mary Beth Bradshaw-Pruitt 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME 306 W. Main Street - Crisfield, MD 21817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final resulting in death) Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Lause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an

Physician / /Medical Examiner

physician

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has

certificate

After this

Physician

/Medical

10a. State

Director

Funeral

2

Completed

Be

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Examiner

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinal must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with t. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Exeminational become.

3altimore, Maryland 21215-0036

the Maryland

Examiner physician and s the burial-transit attending pt signed by page 2 should funeral director,

The law requires that the death certificate be executed

P.O. Box 68760

Division of Vital Records,

Physician:

or Attending

Hospital

To the I within 2.

Physician/Medical 至 Completed 25. Was case referred to medical Be Certification: To n 24 hours after death. e Funeral Director: Aft etely filled in by the fur

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown

examiner?

3 Suicide

29a. Certifier

4 Homicide

31. Date filed (Month)

autopsy 1 ☐Yes 2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 ☐ Pending investigation

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Hall thickway, Crisfield MD 21817

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier

OCT 15

6 ☐ Could not be

determined

29d. Date signed (Month, Day, Year) 12010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Privilage Kaumbunattan 2

State Registrar

completely

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 13, 2010 Vernell Virginia Johnson 8:30 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 🗷 F Director 212-62-0345 67 September 27, 1943 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Extraction or must be rectified at Director 1 ☐Yes 2 No MD Calvert Huntingtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3757 Hunting Creek Road 20639 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 No Specify δ Specify. 3 X Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cook **Public Schools** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi Contee Mackall Marie Kyler ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles W Johnson - son 3856 Sixes Road, Prince Frederick, MD 20678 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 ■ Burial 2 □ Cremation 3 □ Removal from State October 23, 2010 Lusby, MD Zion Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Sewell Funeral Home, P.A. Blady 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 58 **Physician** /Medical Due to (or as a consequence of) Examiner NEMMONIA Sequentially list conditions, if any, he did to cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse quence of) Examiner ME TASTATIC attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 1 □ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this of funeral dire 2 ER/Outpatient 3 DOA Inpatient Medical Certification: To 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Dath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

law requires that the death certificate be executed Box 68760 P.0. Division of Vital Records,

72 hours after

Baltimore, Maryland 21215-0036

State Registrar (Check only one)

29b. Signature and title of certifier

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Prince Frederick, mo 20678 inder 100 31. Date filed (Month, Day, Year)

32. Registra Signature 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

/ayne Elton Johnson State of Maryland / Department of Health and Mental Hygiene								
		Registrar	e of Death	Reg. No		L3		
Physici ledical Exam		wayne file oungon		2. Date of Death Month Day October 8, 201				
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death Prince Frederick		4c. County of Death Calvert			
		Calvert Memorial Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)			M/DD/YYYY) 9. Birthplace (State or	_		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 2 1 9 - 4 8 - 8 6 0 9 1 X M 2 F 6 3	Yrs. Months Days Hours Mir		Foreign			
*		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or	ocation		10d. Inside City Limits	2		
ow any		N/D			1 Yes 2 W No			
Aaryland 28a-f show 1 at once.	ctor	MD Anne Arundel Lothi	at II 10f. Zip Code	10a Ci	itizen of What Country?	_		
nith the Maryland 123a or 28a-f shov notified at once.	Director	4 B Street	20711		USA			
with the 13 and 18 23 and	erall		3. Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - American Indian, Black,	-		
leath r item	Fune	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.			
after al", o	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 No specify:		swhite			
nours		dur	edent's Usual Occupation (Give kind of ing most of working life. DO NOT use ret		Kind of Business/Industry			
36 in 72 in man "	plet	Elementary/Secondary (0-12) College (1-4 or 5+)	Clerk		C.			
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	Completed	17. Father's Name (First, Middle, Last)		e (First, Middle, Maider	rocery Store	_		
215 e file tal Hy ked o	Be C	Elton W. Johnson	İ	K. Laws				
21; ould b il Men s mar	2		failing Address (Street and Number or	Rural Route Number, 0	City or Town, State, Zip Code)	_		
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland near of Health and Mental Hygies and a main. If item 27 is marked other than "natural", or items 23a or 28a-f she main. If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once		3		n, MD 20				
re, s 1 an f Heal If iten		crematory	isposition (Name of cemetery, or other place)		. Location - City or Town, State			
Page Page nent o		4 Donation 5 Other Specify: Metrop	$15/2010_{\rm A}$	lexandria, VA ral Home, P.A.				
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within pergent of Health and Mental Hygiene. Important: If item 27 is marked other thin injury or other traumatic event, the Med		21 Signature of Funeral Service dicensee	22. Name and Address of Facility S e W	ell Fune	ral Home, P.A.			
		23a Part I. Enter the disease, or complications that caused the death. Do not en			nce Frederick, MD	_		
Physician /Medical		failure. List only one cause on each line.	itel the mode of dying, such as cardiac c	respiratory arrest, si	Between Onset and Death			
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of):			- Dodan	-		
	_	Sequentially list conditions, b	**			_		
	ni ne	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause						
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68 certifi anding	ian	23b. was decedent pregnant in the past 12 months? 1 Live birth 2 4 Pregnant at time of death	Fetal death 3Ectopic pregna Other (Specify)	ancy	Month Day Year			
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ires that the signed by t	by P	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		use contribute to the cause of death?	٦		
S, P				1 Yes 2	No 3 Probably 4 Unknown 24b. Were autopsy findings available	_		
Records, The law require ficate has been si, page 2 should b	Completed			autopsy performed?	prior to completion of cause of	Į		
tal Rec tian: The l certificate l	힝			1 ✓ Yes 2 N		╛		
ital Recionant The section, page	å	25. Was case referred to medical examiner?	26.Place of Death (Check			\dashv		
of Vital ng Physician: Ufter this certi	မ	1 Yes 2 No Prospital 1 Inpatient 2 V ER/Outpa 27. Manner of Death 28a. Date of Injury 28b. Tim	g Home 5 Residence Residen	ence 6 Other:	4			
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Division To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by the fu	rtific	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm,		or Town, State)	and Number or Rural Route Number, City	7		
Di To the Hospital within 24 hours a To the Funeral I		4 Homicide 1993 Wajor Road / High	<u> </u>	due to the cause(s) ar		\dashv		
To the Hos within 24 h To the Fur completely	Medical	(Check only one) 2 Medical Examiner: On the bast of my knowledge, death of one) and manner stated.						
5 ½ 5 g	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)	1		
	O.C.M.E. October 9, 2010							
ew 5	30. Name and address of person who completed cause of death (Item 23a)							
		Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201						
Si Regis	ate	31. Date filed (Month, Day, Year) 9 2010 Sensor A. Sauce						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34615 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Oct. Duk Hee Kwon 2010 12:15 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign Country) Korea 1 □ M 2**X**] F Months Days Hours Min. Director None 79 03/27/1931 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10a. State 10b. County be filed within 72 hours after death with the Maryland event, the Medical Examiner must be notified at Director 10d. Inside City Limits 1 Tes 2 No Clarksville Howard 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 6929 Crossfield Court 21029 Korea or items 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Completed 3X Widowed 4 ☐ Divorced Asian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Business Owner Seafood Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e Shin Myung Kwon Moo Duk Kim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sung Jung - Daughter 6929 Crossfield Court Clarksville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Ardent Crematory 4 ☐ Donation 5 ☐ Other (Specify) 10/21/2010 Hanover, MD 21. Signature of Funeral Service Licer see 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MOTASTATI disease or condition WONTH Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ רפומו עשבה ☐ Pregnant at time of death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Year signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 2 No 3 □ Probably 4 □ Unknown Completed 1 Tes plnous 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has b director, page 2 s autopsy death? 1 ☐ Yes 2 ☐ No 2 N Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 🖵 Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence After this Manner Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes Accident 2 No after deatl Director; filled in by the Investigation Suicide 6 🗆 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Funeral C g Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Medic completed (Check within 2. 3 🗌 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Registrar's Signatur

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 10h **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospitat If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** 1 🕅 M 2 □ F 215-42-3879 12. 1946 Sept. Maryland Director 64 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 1 ¥ Yes 2 □ No Director notified Maryland Carrol1 Mount Airy 10e. Street and Number 10f. Zip-Code 10g Citizen of What Country? ь ritems 23a or ner must be n 21771 407 Park Avenue U.S.A. death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 11 Marital Status Department of health and Mental Hygiene. I flem 27 is marked other than "natural", or iten any injury or other traumatic event, the Madical Exercises once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Yes. Give Specify: ş White 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) CVS Pharmacy Elementary/Secondary (0-12) College (1-4 or 5+) 12 Shift Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Woodrow Wilson King, Sr. ၉ Margaret Holt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Carolyn Lee King - Wife 407 Park Avenue, Mount Airy, Maryland 21771 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Pine Grove Cemetery Oct. 19, 2010 Mount Airy, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland Musons orest 20872 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cardiogenic snow Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of):) /Medical aute myocardial infavorion Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and is the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy Live birth 2 Fetal death Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ed by the at detached for 2 🗆 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 performed' 2 DNo 1 TYes 2 No or Attending Physician; 26. Place of Death (Check onl one) 25. Was case referred to medical Be examiner?
1 Yes 2 No Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 2 ER/Outpatient 3 DOA 6 Other (Specify) ၉ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 2 No 1 🗌 Yes 2 Accident eral Director: A filled in by the f 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Could not be 4 Homicide in 24 hours a the Funeral D hpletely filled To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 1/2001

barko

600 North Wolfe St. Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Heta

eson

32. Registrar's Signature

Ashley

31. Date filed (Month, Day, Year)

PA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene state Amend#9perfuneralhome10/21/2010ccdohrb Registrar Amend#20cperfuneralhomeccdology/infoate)4000beath Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 17 2010 5:55P M George Ellsworth Kilby Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Mary's 39431 Harpers Corner Road Mechanicsville st. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth Funeral Days Hours 1 1 2 0 7 1 9 3 3 Months Min Director 79 42 5225 Baltimore. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director MD St. Mary's Mechanicsville 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 39431 Harpers Corner Road Funeral 20659 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 X Yes 2 □ No Black. White, etc. 1 Never Married 2X Married ò Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: 1 and 2 should be filed within 72 hours aft of Health and Mental Hygiene. item 27 is marked other than "natural", other traumatic event, the Medical Exal If Yes, Give 3 Divorced Specify White Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Roofing Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James Kilby Osceola Arnal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20659Page 1 and 2 sl ment of Health a tant: If item 27 is Rose Kilby/ Wife 39431 Harpers Corner Rd. Mechanics ville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any Injury or o cemetery, crematory or other place) 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State BladenshuranD Ft.Lincoln Cem. 10 22 2010 4 Donation 5 Other (Specify) 22. Name and Address of Facility Briscoe-Tonic Funeral Home 21. Sig v v re of Funeral Service Lio€nsee 2294 Old Washington Rd. Waldorf, MD 20601 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death enysician/ Can cer disease or condition resulting in death) 419 Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed Cause (Disease or impury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the a d be detached f 9 Unknown 9 Unknown P.O. I Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ robably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No artem 24a. Was an has autopsy perform certificate Yes 2 director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of within 24 hours after death.

To the Funeral Director: After tompleted filled in by the funer. 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determine # Hospital Medical 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D6 20 42 10/18/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 235 Three Notch Rd., Ste 101, Mechanicsville, Md. 20659 28103 Dr. Karen 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Oct 23, 2010 Physician/ Fredrick Adolf Knobloch 12:58 pm Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 14217 Oakview Drive S.W. Cresaptown Allegany 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 🗆 🔰 2 🗆 F 3. 1<u>931</u> Min. Nov 6, Hours 492-34-9950 **Director** 78 MO Usual Residence of Decedent 28a-f shov 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Cresaptown 1 Tes 2 No 10e, Street and Number ò 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 14217 Oakview Drive S.W. 21502 USA items filed within 72 hours after death 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ò by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: "natural", Completed 3 Xidowed 4 Divorced Korean white 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Glass Industries Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Anton Vincent Knobloch Anna Maria Schmidt Knobloch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coer 14110 Royal Oak Drive Cresaptown N 19a. Informant's Name/Relationship (Type, Print) Jolanda Cannon Daughter MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Rocky Gap Veterans Cemetery 10/27/2010 4 ☐ Donation 5 ☐ Other (Specify) Flintstone MD 21. Signature of Funeral Service Licenses 22. Name and Address of Full Peral Home, PA ames 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ End Stage

Due to (or as a consequence of): Chrome disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of). been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed mass 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has autopsy 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🗙 No Other: 욘 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 2 🗌 No Accident Investigation 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 2, only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 00055325 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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DHMH 17 Rev 7/2009

State Registrar WONSOCK SHIN

31. Date filed (Month, Day, Year)

Bishop

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32. Registrar's Signature

Rd Cumberland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0ctober 19, 2010 Edna May Charsha Little 11:30 рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford 408 North Stokes Street Havre de Grace 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🎾 F Months Days Hours Min May 1938 72 218-32-8300 Director Pennsylvania Usual Residence of Decedent shov 10a. State 10b. County must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f Maryland Har for d Havre de Grace 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a event, the Medical Examiner must be Funeral 408 North Stokes Street 21078 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 No Specify: 3 X Widowed 4 □ Divorced Completed White Specify Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene. Cytec Elementary/Seconday (0-12) life, DO NOT use retired) College (1-4 or 5+) Years Six Laborer Havre de Grace, MD Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Hempile Charsha Mary Ellen Angle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 406 North Stokes St., Havre de Grace, MD 21078 permit. Page 1 and 2 st Department of Health an Important: If item 27 is any injury or other trau Margie E. Breeden (daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Harford Memorial 10/22/10 4 Donation 5 Other (Specify) Aberdeen, Maryland Gardens 21. Sign ture of Funeral Service Licensee Lee A. Partierson & Son Funeral Home Perryville, Maryland 21903-0 mas 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition ava Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): sician and burial-transit resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending advisoration of the stranding advisoration of th Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Ö in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 No 9 Unknown detached g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> page 2 should be Division of Vital Records, Completed 2, No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2. No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 AResidence 6 Other (Specify) မှ 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Natural 5 \square Pending injury □ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Example 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one dtitle of certifie 29c. License number 29d. Date signed (Month, Day, Year) ne and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			State Registrar		Certificate of	Death	1	Reg. No.	010	346	2U
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	Examin	er	122 N. Streeper St			or Location of Death		4c. Co	unty of Death		
÷	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda			8. Date of Birt	h	None 9. Birthi	place (State o	r Foreian
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ar)	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Prin	1) 19b. M	ailing Address (Street	and Number or Rura	al Route Number	; City or Tov	vn, State, Zip (Code)	
	nd 2 sealth m 27		Jean LaBonte - wife	12	2 N. Stree	per Stree	t Balt	<u>imore</u>	, MD 2	21224	
ore			20a. Method of Disposition → Burial 2 □ Cremation 3 □ Remove		sposition (Name of crematory or other pla	ce)	Date	20c. Locat	ion - City or To	own, State	
Baltimore,	t. Pag ntmen rtant: njury		4 Donation 5 Other (Specify)	Crest L	awn Mem. G	rdn.10/25	/2010	Marri	ottsvil	le, MT)
Ba	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Light nice	TA	22. Name and Addre	ess of Facility Har	ry H. W	itzke	's Fami	ly F.H	I.Inc.
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5	To the Hospital or Attending Physician: The law requires that the within 42 hours after death. To the Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.										
	Hos 24 hc Fund leted	Medical	(Check 2 Medical Examiner: On t	the best of my knowledge, dea he basis of examination and/or in oner: To the best of my knowledge	estigation, in my opinio	on, death occurred at	the time, date ar	nd place, and	due to the cau	use(s) and mar	ner stated.
	Nothin Sompl	2	29b. Signature and title of certifier	other: To the best of my knowledg	29c. Licens	-			gned (Month, L		
			> Call MI		030	573		10-	21-10.		
	,		30. Name and addless of person who complete		e, Print)						
	6		Jon K. Minford, M.D.	10710 Charte	r Drive Su	ite G020	Columb	oia, M	D 2104	14	
	Stat Registra	e	31. Date filed (Month, Day, Year) 0CT 21 2010	32 registrar's Signature	barked						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month () Physician/ 175 / Lindley Allen Lentz 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner NICOMICO TENINSULA BEGIONAL Conter SAUSSUM If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 D F Months Hours Min. (Month, Day, Country)
Maryland 82 ily Director 233-40-1037 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 219 Creekside Drive 21804 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☑ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates 1957-1963 3 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Ships Captain 12 Merchant Marine Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Herbert J.J. Lentz Loula Hines Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles J. Griffin 6600 Martin Road, Columbia, Md. 21044 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Allen Cemetery 10/19/2010 Allen, Md. 21810 attle of Funeral Service Licenses 22. Name and Address of Facility Hinman Funeral Home MO0295 11673 Somerset Avenue, Princess Anne, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cau e on each line Immediate Cause (Final Onset and Death MIFFROSCLEROTIC Physician/ ISEASE ITVA Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician by Physician/Medical Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death Yes 1 Yes 2 9 Unknown s been signed by the sahould be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s certificate 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 X No Hospital: Other: မှ 1 Nnpatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural iniury 5 Pending Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d, Date signed (Month, Day, Year) 10 Name and address of person who completed cause of death (Item 23a) (Type, Print) 910 31. Date filed (Month, Day, Year) State OCT 18 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State RegistraMEND#20bperFH, 10/20/10, BMW, McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Valerie Pearson Loftman Medical 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death <u>Takoma Park</u> Montgomery Washington Adventist Hospital ge (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🙀 F Months Hours Min 579-62-7213 57 Director Washington, 5/8/1953 DC Usual Residence of Decedent 3a or 28a-f show t be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No MD Silver Spring Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 526 Thayer Avenue #101 20910 USA **Examiner must** items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or ģ 1 Never Married 2 Married 1 Yes 2 No Specify African American nours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 N Divorced Year or Dates Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry 72 h (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.
27 is marked other than traumatic event, the Me within 7 College (1-4 or 5+) Elementary/Seconday (0-12) secretary Legal Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Page 1 and 2 should be William F. Pearson Alice Geraldine Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Christopher Pearson/Son 8810 Manchester RD #1 Silver Spring, MD 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date UKn-20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematroy 10-16-2010 Beltsville, MD 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service Jicenses 7400 Georgia Avenue, NW Washington, DC 20012 23a. Rar 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. leath. Do not enter the mode of dving, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical **Examiner** Unknown Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Unknown the burial attending physiciar Physician/Medical Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 No for Month Day detached the 9 Unknown P.O. ģ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be de 23e. Did tobacco use contribute to the cause of death? Completed by Records, the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 Yes Division of Vital upleted filled in by the funeral director, 25. Was case referred to dical æ 26. Place of Death (Check only one) examiner? Hospital Other: မ Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at s after death. Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 2 29d. Date signed (Month. Day. Yea of person who completed cause of death (Item 23a) (Type, Print) 00 31. Date filed (Month, Day, Year) ack State

Registrar

			Please Type or Print in Bia			_
			For State of Maryland /	Department of Health and M		0010 01 000
			Registrar	Certificate of Death		. No.2010 34623
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Kyle, Joseph, Lancon		2. Date of Death Month	Day Year 3.4 c ρ M
	Examin	er	4a. Facility Name (if not institution, give street and number) Shock Traume Center	4b. City, Town, or Location of Death Baltimore		4c. County of Death
	Funeral Director		5. Social Security Number 217-31-0525 6. Sex 1 ☑ M 2 □ F 7. Age (In yrs. last bit	rthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	9. Birthplace (State or Foreign Country) MaryLand
	yland f show ed at	ctor		vn or Location	,	10d. Inside City Limits 1 □ Yes 2 ☑ No
	the Mar or 28a- be notifi	Funeral Director	Maryland Montgomery 10e. Street and Number	Silver Sph		. Citizen of What Country?
	eath with ems 23g	unera	324 Stonegate Drive 11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	U.S.A. 14. Race - American Indian,
9003	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	1	1 ☐ Yes 2 🗷 No Specify:	Hican, etc.)	Black, White, etc. Specify: White
21215-0036	hin 72 hor ne. than "nat m Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	a. Decedent's Usual Occupation (Give kind of work done during most of works life. DO NOT use retired) College Student	ing 16	ib. Kind of Business Industry Education
2	d wit lygie ther nt, th	Be C	47 Fathaula Nama (First Middle Lost)		e (First, Middle, Mai	
Maryland	should be file and Mental H is marked of aumatic eve	To E	17. Father's Name (First, Middle, Last) Joseph Lancon, Jr.		Sue Ai	ın Clark
Mai	12 shouth and and 27 is n			b. Mailing Address (Street and Number or Rura 24 Stonegate Drive, S		
re,	1 and of Heal item		20a. Method of Disposition 20b. Place			c. Location - City or Town, State
imo	Page ment c lant: If		4 Donation 5 Other (Specify)	incoln Crematory 10/1		
Baltimore,	permit. Page 1 Department of Indian portant: If if in interpretant on once.		21. Signature of Funeral Service Licensee Ho #1070	11800 New Hampshire	Ave., Si	di Funeral Home, Inc. Lver Spring, MD 20904
			23a. Part 1. Enter the disease, or complications that caused the death. Do shock or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac of	or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death) a. Traumatic Due to (or as a consequence	brain injury		day
Sir.	Examiner	er	Sequentially list conditions, D. ———————————————————————————————————	hide Accide	4	Chylland Between Onset and Death
	ecuted and I-transit	cal Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events c			TO LESS OF THE SECOND S
90	be ex sician burial		resulting in death) Last Due to (or as a consequence d			Policy : The same
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician. To the Funeral Director: After this certificate has been signed by the attending physician.	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown			23d. Date of delivery Month Day Year
P.O.	that the med by e detach		Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
rds,	v requires s been sig should b	eted			1 Yes	2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available
Division of Vital Records,	hysician: The law r his certificate has k Il director, page 2 s	Completed by			autopsy performe	prior to completion of cause of
ital	ician: certific rector,	To Be	25. Was case referred to medical examiner? 1 X Yes 2 No Hospital: 1 X Innatient 2 FR/O	26. Place of Death (Check		
of V	ng Phys fter this ineral dii	ite: To	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 28b.	Time of injury at work?	28d. Describe how i	
sion	Attendii r death. ctor: A y the fu	rtifica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, for	injury work? 3 4 9 A M 1 ☐ Yes 2 No arm, street, factory, office	28f. Location (Stree	wto collTsion It and Number or Rural Route Number,
Divi	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi	Medical Certificate:	Kighu		PLOPKINS LOO	
	n 24 ho	Medic	 29a. Certifier (Check only one) 3 ☐ Certifying Physician: To the best of my knowledge, only one) 3 ☐ Certifying Nurse Practioner: To the best of my knowledge. 	or investigation, in my opinion, death occurred at	t the time, date and p	place, and due to the cause(s) and manner stated.
_	Within the		29b. Signature and title of certifier	29c. License number		. Date signed (Month, Day, Year)
			Ye, MD	P20961		10,10,2010
			30. Name and address of person who completed cause of death (Item 23a) LING XIANG YE, MD. 2	(Type, Print) 2. S Greene Stree Jacks.	t, Balti	move, MD 21201
	Stat Registra	e ar	31. Date filed (Month, Pay Year) 4 2010 32. Registrar's Signature 3.	fall.		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTEM#23a, perpHYS, G909, 11/29/2010, WS. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Arnold Josephus Levin 6:00 P October 12, 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carriage Hill Nursing Home Bethesda Inder 1 Year | If Under 24 Hrs. onths | Days | Hours | Min. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1X M 2□ F **Director** 508-07-2701 03/26/1917 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notitled at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1K Yes 2 No Bethesda MD Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or items 23a or edical Examiner must be Funeral <u>5215 Cedar Lane</u> 20814 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1346 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) <u>Government Relations</u> National Gas Pipline 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ <u>Joseph Levin</u> <u>Helen Kroloff</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Levin / Son 2950 Edgewater Dr. Edgewater MD. 21037-1305 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3】【Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 10/17/2010 | Falls Church, VA 22. Name and Address of Facility
Edward Sagel Funeral Direction Inc.
1091 Rockville Pike Rockville, MD 20852 21. Signature of Funeral Service Licensee Kurt Blake 23a. art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Coronary Artery Disease Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown signed by the pet det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an page 2 certificate 1□ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 24 hours after death. e Funeral Director; After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Bes, mg 00057124 10/15/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Truong Bao M.D. 10110 Molecular Dr. #206 Rockville, MD. 20850
31. Date filed (Month Car. Yar) 2010 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 15, 2010 1:03 p Mabel Helen Lemnah Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Olney Montgomery 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) June 8, 1920 **Funeral** 6. Sex 7. Age (In yrs. last birthday, If Under 24 Hrs. Birthplace (State or Foreign Country) Days 1 🗆 M 2 🔀 F Months Director 008-10-2635 Usual Residence of Decedent 28a-f shov 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 No Silver Spring Montgomery 5 10e. Street and Numbe 10g. Citizen of What Country? Funeral 23a 3701 International Drive, Apt. 253 20906 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Examiner Armed Forces Black, White, etc ō Completed by 1 Never Married 2013 Married ☐ Yes 2 🔀 No Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: White "natural", If Yes, Give 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Federal Government ould be filed with nd Mental Hygien marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Carlton Shepard Mary Flanagan and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norman F. Lemnah/Husband 3701 International Drive, Apt. 253, Silver Spring, MD 20906 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or c ₹ cemetery, crematory or other place)
Gate of Heaven Cemetery 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 2010 Silver Spring, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses ²² Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W,. Silver Spring,MD 20901 23a. Part 1. Enter htt. disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Failure To Thrive disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Atrial Fibrillation Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of Exam nding physician and use as the burial-transit Cause (Disease or iinjury Coronary Artery Disease that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? Yes 2 X No 1 Yes 2 No Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ♣ No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, s after death.

I Director: After this d in by the funeral d 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 1 🔀 Natural 5 Pending injury work?
1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, upleted filled in by 4 Homicide determined City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. EOO 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 3drun D47928 October 15, 2010

Registrar
DHMH 17 Rev 7/2009

State

Georgia Avenue, Silver Spring, MD 20902

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lila M. Bahadori, MD

31. Date filed (Mon

10301

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear Physician/ BURTON W. LEWIS JR. 2:03 P OCTOBER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S **Examiner** PRINCE GEORGE'S HOSPITAL CHEVERLY 8. Date of Birth (Month, Day, DEC 20 9. Birthplace (State or Foreign 5. Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral Hours ILLIMOIS Director 579-50-2573 71 ั้ 1938 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 □ No MD PRINCE GEORGE'S LANHAM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20706 7016 WOOD THRUSH DRIVE Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🏋 No If Yes, Give Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE DEPOT CLERK Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ROSILAND BUTCHER BURTON W. LEWIS SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7016 WOOD THRUSH DRIVE LANHAM, MARYLAND 20706 KATHRYN E. LEWIS/WIFE 20a. Method of Disposition
1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date RIVERDALE, MARYLAND 10-20-2010 RIVERDALE CREMATORY 4 Donation 5 Other (Specify) J. B. JENKINS FUNERAL HOME, INC. Manature of Funeral Service License 22, Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enysician. CARDIAC Medical resulting in death) Due to (or as a consequence of Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner CORGNALY ARTELY -DISTASE or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and deelached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical FAILURE Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant 9 Unknown Pregnant at time of death Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by PNEUMONIA 1 Yes 2 No 3 Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 1 Yes 2 No this certificate Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After injury work? 1 Natural 5 Pending Accident Investigation completed filled in by the 2 Accident
3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

CR_

State Registrar

DHMH 17 Rev 7/2009

HOSPITAL DRIVE

CHEVERLY MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

3001

DNUPAMA LIEELAKANTA

Date filed (Month, Day, Year)

OCT 1 9 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day 2010 Physician/ Dorothy Jeanne Maceira 2:29 р м Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Montgomery Holy Cross Hospital Silver Spring If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Sept. 8, 1927 1 □ M 2 🛣 F 83 Yrs 164-22-5640 Director Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be nortified an Once. 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County Director 1 Yes 2 No MD Silver Spring Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 20902 USA 12212 Berry Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Yes, specify Cuban, Mexican, Puerto Rican, etc. Armed Forces? Black, White, etc. by 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 X Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working College (1-4 or 5+) life. DO NOT use retired) Elementary/Seconday (0-12) Bookkeeper Banking Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Victoria Fehr Wardell Arey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15919 Chieftain Avenue, Derwood, MD 20855 Mark Maceira/Son 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Oct. mator 1 N Burial 2 Cremation 3 Removal from State cemetery, crematory or other place Parklawn Memorial Park 4 Donation 5 Other (Specify) Rockville, Maryland 2010 22. Name and Address of Facility . Signature of Fund Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring 500 University Blvd. W... 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Right Leg Bleeding Examiner Completed by Physician/Medical

Ph_sician/ Medical Examiner

Baltimore, Maryland 21215-0036

physician and s been signed by the sahould be detached has After this certificate To the Hospital or Attending Physician: To within 24 hours after death.

To the Funeral Director. After this certificate completed filled in by the funeral director, page Be |2 Certificate:

Medical

29a. Certifier

(Check

29b. Signature and title of certifier

Kshama Garg, MD 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

	- region and Dicounis							
resulting in death)	Due to (or as a consequence of): Factor 8 Deficiency							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence of):		_					
Cause (Disease or iinjury that initiated events	c. Coronary Artery Disease							
resulting in death) Last	Due to (or as a consequence of):							
	■ d		_					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	23d, Date of delivery Month Day Year						
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death						
		24a. Was an autopsy performed? 1 □ Yes 2 🏿 No 24b. Were autopsy findings avalle prior to completion of cause death? 1 □ Yes 2 🖎 No 1 □ Yes 2 □ No	able e of					
25. Was case referred to medical	26. Place of Death	(Check only one)						
examiner? 1 Yes 2 No	Hospital: 1 😾 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA Other: 4 🗆 Nurs	sing Home 5 Residence 6 Other (Specify)						
27. Manner of Death 1 ★ Natural 5 Pending 2 Accident Investigati								
3 Suicide 6 Could not 4 Homicide determine	1 28e Place of Injury - At home farm street factory office 1 28t 1 ocation (Street and Number of Bural E							

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D60826

29d. Date signed (Month, Day, Year)

October 18, 2010

State Registrar 1500 Forest Glen Road, Silver Spring, MD 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Nellie P. Mazer Month 2010 26 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Frostburg ALLEGANY WMHS Frostburg Nursing& Rehab Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** July 9, Months Days Hours Year) 914 Pennsylvania Director 96 Yrs 218-60-0341 Usual Residence of Decedent 28a-f show 10a. State within 72 hours after death with the Maryland Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No MD Lonaconing Garrett 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21539 1433 Sam Crow Rd. USA items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Force Black, White, etc. "natural", or ģ 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Mankamyer Laura Murray other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 227 Shaw St., Frostburg, MD 21532 Carl Mazer/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State injury or Mt. Zion Cemetery Dct. 29, 2010 Frostburg, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A. P.O. Box 275, Grantsville, 23a. Part 1. Ette the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIDMYO Physician/ disease or condition Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of sician and burial-transit Due to (or as a consequence of) attending physician for use as the buria Physician/Medical requires that the death certificate be Records, P.O. Box 68760 as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death Month Year the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by be det 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law page 2 autopsy perform After this certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical **Division of Vital** funeral director, Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at (28d. Describe how injury occurred (Month, Day, Year) 1 Matural injury 5 Pending after death. 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my onlying death occurred at the time, date and place, and due to the cause Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Harjit Sidhu, 925 Bishop Walsh Rd., Cumberland, MD 31. Date filed (Month, Day, Year) Registrar's Signature OCT 28 2010

Hollon

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

469

21502

DCT0BER26 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Gloria October 12% 2010 20:45Р. м Jane Moss Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Silver Spring **Examiner** 4c. County of Death
Montgomery Holy Cross Hospital Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 218-38-6168 1 M 2 X F 69 Months Hours Jan: 10", 1941 Washington, DC Director Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Beltsville 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral 12006 Beltsville Drive 20705 United States and Mental Hygiene. is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married þ within 72 hours after Baltimore, Maryland 21215-0036 1 🗆 Yes 2 🗓 No White If Yes, Give 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Meat Wrapper Giant Food 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Alton Turner Lillie Jane Kelley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Page 1 and 2 sh Department of Health a Important: If item 27 is 4718 Quimby Avenue Beltsville, Maryland 20705 Lorrie A. Kelly -daughter Injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Fort Lincoln Cemetery 10/18/2010 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 21. Signature of Funeral Service Licen Bonald VoresBoles Wardt Funeral Home, PA any 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Ischemic Non Hemorrhaeic Stroke Medical resulting in death) Due to (or as a consequence of): Examiner Atrial Fibrillation Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence on) Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No Month Pregnant at time of death the detached 9 Unknown s been signed to should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Acute Renal Failure; Toxic Metabolic Encephalopathy Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? autopsy certificate 1 ☐ Yes 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital A Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D69946 October 13, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Emeric Palmer, M.D. HCH 1500 Forest Glen Road Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year) State

Registrar

OCT 1 4 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Marea M. McMullan 12:34pM 2010 October Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Wilson Health Care Gaithersburg 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral Country Maryland 1 □ M 2 🕅 F Months Hours Marty Pay 1929 213-24-3541 Director 81 Usual Residence of Decedent 23a or 28a-f show ist be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 No Silver Spring Maryland Montgomery 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 3472 Chiswick Court 20906 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11 Marital Status Black White etc. þ 1 Never Married 2 Married "natural", or 1 Yes 2 1 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: 3 X Widowed 4 Divorced White Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Aerospace Corp. Administrative Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file
Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ဨ Emma Elizabeth Hawkins William Oscar Marshall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3472 Chiswick Court, Silver Spring, MD 20906 Jenny L. Wilson/Sister-in-Law 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Parial 2 🗆 Cremation 3 🗔 Removal from State 10/16/2010 Suitland, Maryland 4 Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 21. Si nature of Funeral Service Ucense 22. Name and Address of Facility Hines-Rinaldi Funeral Home, New Hampshire Ave., Silver Spring. MD 20904 1800 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ estin disease or condition Medical resulting in death) Due to (or a a consequence of): Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examine burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed and Due to (or as a consequence of): physician Physician/Medical the IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Month Day Year Pregnant at time of death signed by the at d be detached fo 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate Ves 2 25. Was case referred to medical Hospital or Attending Physician: director, 26. Place of Death (Check only one) Be examiner? Other: 2 No 1 🗌 Yes ြု 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month. Day, Year) October 11,2010 1. Dahut B 30. Name and address of person who completed cause of death (Item 23a) HICOBERT BIRSCH 31. Date filed (Month, Day, Year)

State

Registrar

OCT 14

			. For	State of M									•	01.601	
			- State RegistraMEND#26perMD,		MbCo	Cei	rtificate	of D	eath			Reg. No	010	34631	
	Physici	an	Decedent's Name (First, Middle, Language)								2. Date of De Month	Da		3. Time of Death 8:50 A M	
- want	/Medic	al	George Wil. 4a. Facility Name (If not institution, gi		hling	3	4b. City, To	wen or l	Location		Octobe		2010 County of Dea		
	Examin	er	20400 Epworth Ct						sburg				lontgome		
	Funeral		Social Security Number 6.	Sex 7. Ag	e (In yrs. la	ast birthday)	If Under 1		If Under a		8. Date of Bi (Month, D	rth av. Year)	9. Bir	thplace (State or Foreign	
	Director		100-16-9919	1 X M 2□F {	37	Yrs.	WIOTHITS	Juju	Tiodis	IVIII.	04/24/	1923	New	York	
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits	
	Mary I sho	to	Florida Okaloosa	ı	Nice	eville								1 ☐ Yes 2 ☑ No	
	h the)irec	10e. Street and Number		1		10f. Zip C	ode				10g. Cit	tizen of What Co	ountry?	
	ath wif	Funeral Director	4107 Callaway Dri	lve			3257					USA	1		
	tems	nue	11. Marital Status	12. Was Decedent Armed Forces?	10/	3. 13. Y	Was Deceder f Yes, specify	nt of His / Cuban	spanic Orig n, M <i>e</i> xican	gin? (Spe , Puerto f	cify Yes or Ne Rican, etc.)	0-	 Race - Ame Black, Whit 		
36	rs afte	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ If Yes, Give Year or Dates:	196.		1□Yes 2₹	No	Specify:				Specify: whi	ite	
9-0	be filed within 72 hours after death with the Marylan ital Hygiene. ed other than "natural", or Items 23a or 28a-f show event, the Middeal Evander is ust by notified at	ted	15. Decedent's E	ducation		16a. Dece	dent's Usual	Occupa	tion	h a d com ad da		16b. K	and of Business		
21	ithin 7 ne. nan "r	Completed	(Specify only highest gi Elementary/Secondary (0-12)	College (1-4or s	5+)		kind of work DO NOT use		aring most	OFWORK	ig				
121	filed withir Hygiene. other than ent, the M		17. Father's Name (First, Middle, Las	2		Seli	Emplo		18 Motho	r'e Namo	(First, Middle		inet Co	mpany	
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. s marked other than "natural", or Items 23a or 28a-f show umatic event, the Medical Eventine I, ust by notified at	To Be	George Joseph Me												
aryl	s t and 2 should f Health and Mer item 27 is marke other traumatic	۲	19a. Informant's Name/Relationship			19b. Mailir	ng Address (5	Street a		ry Kohischrieber mber or Rural Route Number, City or Town, State, Zip Code)					
Ž	and 2 sauth au 27 is er trau		Mary Jo Mehling	/ Wife		4107 (Callaw	ay I	rive	Nic	eville	, FL	32578		
ore	ges 1 and He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Pt	ace of Dispo emetery, cren	sition (Name natory or othe	of er place) 0		o8,201	20c. Le	ocation - City or	Town, State	
Baltimore,	nit. Pag artmeni ortant; injury e		4 ☐ Donation 5 ☐ Other (Spec	Donation 5 □Other (Specify) Heritage GardensCemetery Mold M									ceville	, FL	
Bal	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		21. Signature of Funeral Service Rice	entree M			Home ., DC 2	20007							
П			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death												
	Physician		Immediate Cause (Final disease or condition resulting in death)	Metas	tatic	Lung	Cance	r						Onset and Death	
4	/Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):									
		ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or as	a consequ	ence of):									
	euted sign	Examiner	that initiated events	c.											
,092	te be executed ysician and e burial-transit		resulting in death) Last	Due to (or as	a consequ	ence of):									
876	eath certificate be executed attending physician and for use as the burial-transit	dical	•	d											
89 x	certified iding page as	/Me	IF FEMALE:	23c. If yes, outcome	of pregnar	ncv							Ood Data of da	Il annu	
Вох	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	death 3[Ectopic pred Other (spec						23d. Date of de Month	Day Year	
P.O.	The law requires that the death certifical ate has been signed by the attending phy agge 2 should be detached for use as the	Physician/Medi	9 Unknown	9 ☐ Unknown											
	ires tha signed I be det	by P	Part II. Other significant conditions	contributing to death b	ut not resul	Iting in the u	nderlying cau	se giver	n in Part I.					o the cause of death?	
of Vital Records,	w requir s been si should I	ted									1 🗆	Yes 2	No 3□P	robably 4 Unknown	
ec	has b	Completed									24a. Was	psy	24b. Were a prior to	utopsy findings available completion of cause of	
a											1 □ Yes		death? 1 ☐ Yes	s 2□No	
V:t	Physician: r this certific ral director, I	Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 🕅 No	Hospital:		-D/O-11	nt 3 □ DOA	Othor		-	(Check only		daughte	er's	
		n: To	27. Manner of Death	28a. Date of Inju	iry	28b. Time of		: Injury Work?			8d. Describe			ed Maresidence	
ion	Attending or death. ector: Afte by the fune	atio	1X Natural 5 Pending 2 Accident investigation		y, rear)	Injury	М		r es 2□t	No					
Division	or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined		ury - At hor c. (Specify	me, farm, str	eet, factory, o	ffice		2	8f. Location City or To	Street ar	nd Number or R e)	ural Route Number,	
	Hospital of hours af Funerat D		29a, Certifier 1 X Certifying P	Novelelen. To the best	of multipass	uladaa daad	b	Almo Aisso	- 404- 00			/-	-)	a atatad	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical		Physician: To the best aminer: On the basis of and manner st	of examinat										
_	To the within 2 To the complete	Σ	29b. Signature and title of certifier	Sulvan		0 + 4		icense 0350	number				ate signed (Mon . 4, 20		
	12		The Couper's					اررن	507			JUL	• +, 20	10	
			30. Name and address of person who Deepa Subramania					Was	shino	ton	DC 20	007-	2113		
	Sta		31. Date filed (Month, Day, Year)	32/Registr	ar's Signat	· fa	del.	.,		,	20 20	<u> </u>			
	Registr		OCT 1 4 20	110 Seku	u p	. 190									
DH	MH 17 Rev 1/2	001													

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 2010 10:00 Ам Paul Samuel Massey Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Bethesda Bethesda Rehab Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth **Funeral** Days Hours Months March Day Year 1939 North Carolina 71 Yrs. Director 241-56-1195 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director Bethesda 1 Yes 2 No MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20814 5721 Grosvenor Lane United States within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indiar rmed Forces?

X Yes 2 \(\sum \) No Black, White, etc. African-1 Never Married 2 Married Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after pepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or þ If Yes, Give Year or Dates 1962 – 1963 1 ☐ Yes 2 A No Specify: 3 Widowed 4 Divorced Specify:American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Office Assistant HUD Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edward Massey Mary Dunston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Guess, Sister 400 Potomac Valley Drive, Fort Washington, MD 20744 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Ft Lincoln Crematory 10/13/2010 Brentwood, Maryland 4 Donation 5 Other (Specify) M01463 22. Name and Address of Facility Simple Tribute Signature of Fureral Service Licensee 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Er shock, of heart fafure. List only one cause on each line.

Immediate Cause (Final disease or condition and action as the cause of each line. ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Onset and Death Physician/ Advanced Dementia Medical Due to (or as a consequence of) Examiner Epilepsy Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hypoxemia Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 the for use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Other (specify) Yes 2 No signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 M Unknown page 2 should 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? 1 Yes 2 No Yes 2 N director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 A Residence 6 A Other (Specify) Hospital: 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral to 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury work? 5 Pending 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🕱 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 7/2009

State

Grosvenor Lane, Bethesda, MD 20814

5721

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harding-Omar

<u>Milagritos</u>

31. Date filed (Month, Day, Year) **OCT 1 4** 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State	of Marylar		artment <i>tificate</i>		alth and M	-	21		34633	
			Registrar 1. Decedent's Name (First, Middle	a Last)		Cer	lincate	OI Dec	1	2. Date of De	Reg. Né.	010	3. Time of Death	
	Physicia	n/								Month Octobe	Day	2010	10:10pm M	
	Medic Examin	_	Joao Lopes Mar 4a. Facility Name (if not institution		mber)		4b. City, To	own, or Loc	cation of Death	<u>oc cobe</u>		unty of Death		
	Lxamiii	-	Montgomery Gen				01ne	У			Мо	ntgome	ry	
	Funeral		5. Social Security Number	6. Sex 1 🔀 M 2 □ F	7. Age (In yrs.		If Under 1 Months		Under 24 Hrs. lours Min.	8. Date of Bir		9. Birti _ Cou	hplace (State or Foreign	
	Director		214-21-3384	T LALM 2 LL F	53	Yrs.				03/25/	1957	Por	tugal	
	nd how at	'n	Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Loc	cation						10d. Inside City Limits	
	aryla ka-fs ified	ect	Maryland Montg	omerv	Oln	ev					1 ☐ Yes 2 🛣 No			
	or 28 e not	Dir	10e. Street and Number	Omer y	0.211		10f. Zip C	Code		10g. Citizen of What Country?				
	s 23a ust b	Funeral Director	18527 Rushbroo	ke Drive_			20	832	United States					
	death item ner m		11. Marital Status	Armed Fr		l.S. 13. V	Vas Deceder Yes, specify	nt of Hispa y Cuban, N	nic Origin? (Spe Mexican, Puerto F	cify Yes or No- Rican, etc.)	14.	Race - Amer Black, White		
36	after Il", or xami	Completed by	1 ☐ Never Married 2 🛣 Mar 3 ☐ Widowed 4 ☐ Divorced	. If Yes, Gi	2 🔀 No ive	1	☐ Yes 2	⊠ No S	Specify:		Spe	ecify: Wh	nite	
8	atura cal E	ete	200000000000000000000000000000000000000	Year or Dent's Education	Jates.	16a. Deced	lent's Usual	Occupatio	n	-	16b. Kind	Kind of Business Industry		
215	n 72 h an "n Medi	mp	(Specify only higher Elementary/Seconday (0-12)	est grade completed College (1-4 or 5+)		kind of work O NOT use r		ng most of workii	ng				
2	withi giene giene rer th		8			Fore	eman				lon			
p	tal Hy tal Hy od oth event	To Be	17. Father's Name (First, Middle,						s. Mother's Name			name)		
<u> </u>	uld be i Men narke natic	-	Clemerio Marti	-					Maria An				0.40	
Mai	2 sho th and th is r		19a. Informant's Name/Relations		`				Number or Rura				Code)	
Baltimore, Maryland 21215-0036	e 1 and 2 should be filed within 72 hours after death with the Maryland to the Hath and Mertal Hygiene. It of Health and Mertal Hygiene. It is marked other than "natural", or items 23a or 28a-f show for other traumatic event, the Medical Examiner must be notified at	1	Rosa M. Arante 20a. Method of Disposition	s (Spouse		Place of Dispo	sition (Name	e of		Date		tion - City or	Town, State	
<u>o</u>		l.	1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (cemetery, crem te of I	Joorton	Com	Oct.	15,2010	Silve	er Spr	ing, Marylan	
計	permit. Page Department (Department in Department	1	21. Signature of Funeral Service		1 Ga	122	. Name and	Address o	f Facility De Park D MD 20	Vol Fur	eral	Home	,	
ñ	a de la company	1 18	Let 1	Dellos		Ga	ither	peer sburg	, MD 20	77 ^e				
			23a. Part 1. Enter the disease, o shock, or heart failure. List	r complications that only one cause on e	caused the dea	ath. Do not ente	er the mode	of dying, s	uch as cardiac o	r respiratory ar	rest,		Approximate Interval Between	
Ŧ	hysician/		Immediate Cause (Final disease or condition		Ca	rdia	1	arr	rest				Onset and Death	
	Medical Examiner		resulting in death)	Due to	(or as a conse	quence of):		0	c = 1.	. 10. 6.0	1.	/		
	Lxammor	ē	Sequentially list conditions,	b. — Due to	Hype	22+em	4000	0	Cardio	vascu	ara	Bell	2	
	ed	m in	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	C Due to	ue to (or as Ansequence of):							- 1		
	xecut n and al-trar	Examiner	that initiated events resulting in death) Last	c. Due to	o (or as a conse	quence of):								
09	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affect death. To the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director. Attended to the funeral director, page 2 should be detached or use as the burial-transit.	dical		d										
876	ificate ng phy as th	Med	IF FEMALE:		_									
Ø ×	h cert tendir or use	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 🔲 Live	utcome of pregr e Birth 2 🗆 Fe	etal death 3	Ectopic pr				230	d. Date of del	livery Day Year	
ñ	the at	ysic	1 Yes 2 No	4 ☐ Pre 9 ☐ Uni	egnant at time o known	f death 5 L	☐ Other (spe	ecity)				William	54,	
Ŏ.	nat the	/ Ph	Part II. Other significant conditi	ions contributing to	death but not re	esulting in the u	ınderlying ca	ause given	in Part I.	23e. Did	tobacco use	contribute to	the cause of death?	
S, F	signe d be	d by	91	eep.	apre	a_				1 🗆	Yes 2□	No 3□P	robably 4 🛱 Unknown	
ord	requ been shoul	lete		1	{					24a. Was			topsy findings available	
Records, P.O. Box 687	e has age 2	Completed								auto	ormed? 2 No_	death?	completion of cause of	
<u>e</u>	an: The tiffical tor, po	BeC	25. Was case referred to medical examiner?					26. Place	of Death (Check		2 23 110			
Ë	nysici lis cer direc	2	1 Yes 2 No	Hospital:	Inpatient 2			Other:	4 Nursing Ho	me 5 Res	idence 6 🗆	Other (Spec	ify)	
o	fiter th	ate:	27. Manner of Death 1 Natural 5 □ Pend	/// // -	e of injury onth, Day, Year)	28b. Time of injury		c. Injury at work?		28d. Describe	how injury o	ccurred		
Division of Vital	ttendi death tor: A the f	Certificate:	2 Accident Invest 3 Suicide 6 Could	tigation and hot be	ce of Injury - At I	home form str	M eet factory	_	s 2 No	28f Location	Street and N	lumber or Ru	ral Route Number,	
Ν	after after Direc	Se	4 Homicide deterr		ding, etc. (Spec		eet, lactory,	onice		City or To	wn, State)	amber or rie	rai riosto riamboli	
Δ	spita nours neral	Medical	29a. Certifier 1 Certifyin	g Physician: To the	best of my kno	wledge, death	occured at the	he time, da	ate and place, an	d due to the c	ause(s) and r	nanner as sta	ated.	
	he Ho in 24 I he Fu	Med	(Check 2 ☐ Medical only one) 3 ☐ Certifyin	Examiner: On the bag Nurse Practioner	asis of examinat r: To the best of	ion and/or inves my knowledge,	tigation, in m death occum	ed at the til	death occurred at me, date and plac	t the time, date ce, and due to t	and place, ar he cause(s) a	nd due to the nd manner as	cause(s) and manner stated.	
	5 4 5 D		29b. Signature and title of certific	er e	110		1	License no			29d. Date s	signed (Monti	4	
				una	HI)		`	009	79		1		10	
			30. Name and address of person			em 23a) (Type, I 101 P≁1	nce P	h 111 1	ip Drive	. 01nes	v. MD	20832		
	Sta	te.	Aruna Kumari Pa 31. Date filed (Month, Day, Year)	3.					- PIIVE	, Jine	, ,		-	
	Registr		OCT 14	2010 Ce	Registrar's Sign	B. 194								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) October October Physician/ Mills, Sr. 2010 Richard D. 3:30p M Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Montgomery White Horse Lane 2421 Silver Spring 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth Country) Ohio **Funeral** (Month, Day, Yea ct. 12, 1 Days 1 **X**M 2 🗆 F Months 579-36-2375 78 Yrs 1931 Director Oct Usual Residence of Decedent 3a or 28a-f show t be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State with the Maryland Director Silver Spring Montgomery 1 Yes 2 No MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20906 23a White Horse Lane and Mental Hygiene. is marked other than "natural", or items 23a aumatic event, the Medical Examiner must t 2421 United States within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married ģ Maryland 21215-0036 1 Tes 2 No Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4yrs Elementary/Seconday (0-12) World Bank Research Specialist of Health and Mental Hygi of Health and Mental Hygi fitem 27 is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edward T. Mills 2 Kathryn Chandler Lomax 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2421 White Horse Lane, Silver Spring, Maryland 20906 19a. Informant's Name/Relationship (Type, Print) Ghislaine L. Mills / wife injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 s
Department of IImportant: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 10/15/2010 Silver Spring, MD Gate of Heaven Cem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service Licenses ' The 20012 7400 Georgia Avenue, NW, Washington DC re 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) +nysician/ Malignant Melanoma Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) sician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? performed? 2 🗆 No certificate 2 X N Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director. **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Tes 2 😾 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide iniury 5 Pendina 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Exifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year, October 12, 2010 29b. Signature and title of certifie M D D0060050 3

State Registrar parke

gistrar's Signature

1396 Piccard Drive, Rockville, Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Mahrukh M. Hussain

31. Date filed (Mont)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2010 34535

Jonald E Moore		- For State Certificate of Death legistrar			. No.	
Physiciar	1/	1. Decedent's Name (First, Middle,Last)		Date of Death Month	Day Year	3. Time of Death 1806 hrs
Medical Examin		Donald E. Moore	wn, or Location of Death	Month I October 17,	4c. County of Death	
		4a. Facility Name (if not institution, give street and number) Southern Maryland Hospital 4b. City, To Clintor			Prince George	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under			(MM/DD/YYYY) 9. Bird Foreig	
Director	-	220 26 4382 1 Months 82 Yrs. Months	Days Hours Min	June 30,	1928	untry) MD
b	- 1-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
ow any		10a. State 10b. County 10c. City, Town or Location 10c. State 10c. City, Town or Location 10c. City, Town or Locat	0			1 Yes 2 No
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number 10f. Zip 0	Code	100	. Citizen of What Cour	itry?
e Pigi	힐	7410 South Osborne Road	20772		United States	3
th with ems 23	Funeral	1 Never Married 2 77 Married Armed Forces? If Yes, specify	t of Hispanic Origin? (S Cuban, Mexican, Puerto		14. Race - Ameri White, etc.	can Indian, Black,
er dea	∄	1 1 1 1 1 1 1 1 1 1	X No specify:		Specify: Whit	te
urs afi	좕	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual C	ccupation (Give kind of		16b. Kind of Business/I	ndustry
6 172 ho	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+) Foreman	ing life. DO NOT use ret	irea)	SHA	
within spene.	틹	17. Father's Name (First, Middle, Last)	18 Mother's Name	e (First, Middle, Ma	aiden Surname)	
MD 21215-0036 at 2 should be filed within 7 lith and Mental Hygiene. m 27 is marked other than a mate event, the Medica	Be C	Percy Moore	Franc			
212 ould b d Ment s mark		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address	(Street and Number or I			
MD id 2 sh lith an an 27 i	L		Osborne Road,		Lboro, MD 20/ 20c. Location - City or	
Baltimore, permit. Pages l an Department of Hea Important: If iter njury or other tr	-	20a. Method of Disposition 20b. Place of Disposition (Name to the place) Cremation 3 Removal from State crematory or other place)		21, 2010	•	
timent trant:	1	4 Donation 5 Other Specify: Trinity Episcopal 21. Signature of Funeral Service Licensee 22. Name and A			Upper Marlbo	
Ball permi Depar Impo injur			oad, Clinton,		опе,шк оооо	Old Alexandria
Physician	7	23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of failure. List only one cause on each line.	dying, such as cardiac o	or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
/Moi al Examiner	1	Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascula	ar Disease			Death
	1	or condition resulting in death) Due to (or as a consequence of): b.				
	盲	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	Medical Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
ecuted and transi	<u></u>	d		<u> </u>		
O, be ex	잃	UNPENDED AMENDED			Loo I Bets of delices	
876 tificate ng phy as the		IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 Ectopic pregna	ancy	23d. Date of delivery Month	ay Year
Ox 6 ath cer attendi	Physician/	4 Pregnant at time of death 5 Other (Speci	fy)			1
b. Be the de by the ched f	훕	Part II. Other significant conditions contributing to death but not resulting in the underlying of	cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
P.C es that igned be deta	2			1 Yes	2 No 3 Prot	ably 4 Unknown
rds, requir	Completed			24a. Was ar autopsy		topsy findings available completion of cause of
eco he law ate has age 2 s	틹			perform 1 V Yes 2		s 2 No
al R	a l		6 Place of Death (Check			
F Vit		1 Yes 2 No Inpatient 2 FR/Outpatient 3 DO	Otner Nursi	ng Home 5 R	esidence 6 Other	:
n of ding I. h. the functions of the control of the		27. Manner of Death 28a. Date of Injury 1 ✓ Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28b. Time of Injury	1 Yes 2 No	200. Describe no	ow injury occurred	
isio Atter er deat rector 1 by th	igat 	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory,	office building, etc.			ral Route Number, City
Div	Certification:	4 Homicide determined (Specify)		or Town, Sta	ate)	
		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the (Check anly one) 2 Medical Examiner: On the basis of examination and/or investigation, in my				
To th within To th comp	Medical	and manner stated.	License number		29d. Date signed (Mo.	
		1	O.C.M.E.		October 18, 2010	
M	ŀ	30. Name and address of person who completed cause of death (Item 23a)				
723 10+1			Street, Baltimore, I	MD 21201		
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature OCT 2.0 2010				
Registi	-	ULIZII (UIU CENERAL PORTE				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death Month Day 10/12/2010 MCPHATTER Physician/ ONNIE 10:29 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE"S THOMAS MOORE NURSING HYATTSVILLE HOME Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □XM 2 □ F Months Days Hours Min. 2/1/1954 Washington, **Director** 577-72-5734 Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 🖁 Yes 2 🗆 No Maryland Prince George's Bowie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 20715 13517 Arrowwood Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examirance. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify: Specify: Completed 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) General Accounting Off. 12 Bindary Worker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Henry Lee Mc Phatter Cremolia Melton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mac Mc Phatter / Brother 3517 Arrowwood Lane Bowie, Maryland 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/18/2010 Lincoln Memorial Suitland, Maryland 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service Licensee M00981 Rarle 5538 Marlboro Pike Forestville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Atheroscleratio Cardiovascular disease disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed has been signed by the attending physician and e 2 should be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Year Month Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Cardionyopath 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an ongetive performed Yes 2 this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 2 No 1 🗌 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred I Director: After the in by the funeral 1 Matural 5 Pending Accident
Suicide 1 Yes 2 No Investigation within 24 hours area
To the Funeral Director Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. з 🗌 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0063681 13/10

State Registrar 1835 University Blvd. Hyattsville, Maryland 20783

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ajit Kurup M.D.

31. Date filed (Month, Day,

OCT 2 0 2010

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		For State	State of Ma	-	epartment of H Certificate of L			/ / / /	0 34637
		Registrar 1. Decedent's Name (First, Middle, La	net)		Jerincale or i	Jean	2. Date of Death	g. No.	3. Time of Death
Physicia	an						Month	Day Ye	ar
/Medic		Barbara As 4a. Facility Name (If not institution, gi	nn Miller		Ab City Town or	Location of Death	October	14 2010 4c. County of E	
Examin	er		ve street and number)						
Famous 1		1148 Amber Way 5. Social Security Number 6.	Sex 7. Age	(In yrs. last birth	Owings	If Under 24 Hrs.	8 Date of Birth	Calve	
Funeral Director			1 □ M 2 💢 F		rs. Months Days	Hours Min.	8. Date of Birth (Month, Day,)	Year)	Birthplace (State or Foreign Country) ash., D.C.
		Usual Residence of Decedent		<u> </u>			02-04-19	JOI MG	asii., D.C.
yland		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
Mar a-f sl	Director	MD Howard		La	urel				1 □Yes 2 No
h the	ir	10e. Street and Number			10f. Zip Code		100	g. Citizen of What	: Country?
h wit	a	9450 Canterbury	Riding		207	723		USA	
dea	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was Decedent of H	ispanic Origin? (Sp	ecify Yes or No-	14. Race - A	American Indian,
or ite	F	1 ☐ Never Married 2 🔀 Married	1 □Yes 2 N If Yes, Give	0	1 ☐ Yes 21 No	Specify:	nicari, etc.)		/hite, etc.
iral",	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		TETICS EXTINO	орсону.		Specify:	white
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2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Evaniner must be notified at	ဥ	Joseph	(T	Elias		Ethel	Viola	Cunning	
d 2 sł th an 7 is r traur		19a. Informant's Name/Relationship		I	Mailing Address (Street				
1 and Health em 27 ither tr		John P. Miller,	Jr., spouse		319 Millbroo			1D 2070 Oc. Location - City	
Pages nent of I int: If ite		1 🕅 Burial 2 ☐ Cremation 3 [Removal from State	_	Disposition (Name of crematory or other place	1		Ĩ	
pormit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Dipartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Evaninar must be notified at once.		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		Cedar	Hill Cemete	ery : 10-1	9-2010 S	Suitland	, MD
D perm Impo		21. Signature of Funeral Service Lice	insee Cur	Tribunda .	22. Name and Address				e, P.A. 20736
10.119		23a. Part 1. Enter the disease, or con	nplications that caused	the death. Do no				_	Approximate
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Examiner				,	,.				
7 4	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of):				
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be executed sician and burial-transit		resulting in death) Last	Due to (or as a	consequence of):				
cate be executed physician and the burial-transit	dical		_d						
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e des	Sici	1 □Yes 2 XNo	4 ☐ Pregnant at 9 ☐ Unknown		5 ☐ Other (specify) _	,		Month	Day Year
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sician: The certificate irector, pag	Be (25. Was case referred to medical examiner?					h (Check only one)		
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or At fter d Sirect in by	Certification: To	4 Homicide determined		ry - At home, farn . <i>(Specify)</i>	n, street, factory, office		28f. Location (Stre City or Town,	eet and Number o State)	or Rural Route Number,
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To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exe	mysician: To the best of miner: On the basis of and manner sta	examination and	death occurred at the tir or investigation, in my o	pinion, death occur	red at the time, da	te and place, and	er as stated. due to the cause(s)
To th withir To th	Me	29b. Signature and title of centifier			29c. Licens	e number	29	d. Date signed (N	fonth, Day, Year)
		Ra. AlVII			DI	1324	00	ctober 15	5, 2010
1 w		30. Name and address of person who	completed cause of de	eath (Item 23a) (T	ype, Print)				
in 10		Kaymon AN	oble UI)	1882	Merrina	e Ct	Prince	Fred.	u()
Stat Registra		31. Date filed (Month, Day, Year)	32. Registra	s Signature	B. Sall	,			/
negistra	al	Ut,}	2371110	enewa,	D. Marke				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			DOCTORS COM 5. Social Security Number	MUNITY HO		yrs. last birthday)	If Under		HAM If Under	24 Hrs	8. Date of Bi		PRINC		ORGE 'S place (State or Foreign	_
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	and show	ō	Usual Residence of Decedent 10a. State 10b. County		10	c. City, Town or La	cation							1	0d. Inside City Limits	_
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yland	ld be f Menta arked atic e	ဍ	Alexander	Moyer							assie M					_
Mar	12 shou alth and 27 is m ir traum		19a. Informant's Name/Relationsh Charles Mansfi		/Son		ng Address Plea								code) 20721 e, Md.	
baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 □ Cremation		n State	20b. Place of Dispo	matory or o	ther place			Date			· City or To		
	nit. Pa bartme bortan injuny		A	□ Donation 5 □ Other (Specify) Md. Veterans Cemetery 10-20-10 Chel gnature of Funeral Service Licensee 22. Name and Address of Facility Capitol Mortuary												
ŏ	a m Dec	110	Marry	Art 1. Enter the disease, or complications that caused the death bo not enter the mode of dying, such as cardiac or respiratory arrest,												
	4		23a. Part 1. Enter the disease, or shock, or heart failule. List of Immediate Cause (Final	complications that nly one cause on e	caused the ach line.	death Do not ent	er the mode	e of dying	ı, such as	cardiac o	or respiratory a	rrest,		1	Approximate Interval Between Onset and Death	
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00/00 X00	certific nding p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou			7						23d. Da	te of deliv	ery	
באר בי	To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknowrf		gnant at tim	Fetal death 3 be of death 5	Other (sp		/				Мо	nth	Day Year	
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ונק אונק	ysicia is cert direct	To Be	examiner? 1 Yes 2 No	Hospital:	Inpatient	2 ER/Outpatie	nt 3 🗆 DC	Othe	r·		ome 5 🗆 Resi	dence	6 🗆 Othe	er (Specify)	
5	ng Ph fter th ineral		27. Manner of Death 1 Natural 5 □ Pendin	28a. Date (Mor	of injury oth, Day, Ye	ar) 28b. Time o	f 28	8c. Injury work?		. 1	28d. Describe	how inju	iry occurre	ed	•	
	ttendi death. tor: A the fu	Certificate:	2 Accident Investig	gation		At home form at	M		Yes 2 🗆	No	001	D44-	m at A to some by	ar ar Driva	Route Number,	_
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	Hospi 24 hou Funer eted fill	Medical	(Check 2 Medical E		sis of exami	nation and/or inves	tigation, in r	my opinior	n, death od	ccurred a	t the time, date	and plac	e, and due	e to the ca	use(s) and manner state	ed.
	To the within To the comple	Σ	only one) 3 L Certifying 29b. Signature and title of certifier	Nurse Practioner	to the best	or my knowledge,		. License		and plac	e, and due to ti			d (Month,	_	_
			thomas	Han	em		V	MDI	53	371	8		10/	13/	10	
2	,4		30. Name and address of person v	who completed cau	se of death	(Item 23a) (Type, I	Print)	bra	ale l	Cl	10.1.	0	n	10.	207010	
	Stat	e_	Thom Q5 Ha. 31. Date filed (Month, Day Year)	vho completed cau	Regis tr ar's S	OIIO O	000	NU	CICK	4.	CUAR	الاف	1	101	00,00	_
	Registra		31. Date filed (Month, Day, Year) 0CT 1 9 2010	Cener 1	A. 1	Signature								_		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Oct. 12 2010 1:10 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince Georges Riverdale Crescent Cities Nursing Home If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days 1⊠M 2□ F Yrs Dec 24, 1943 NC 66 Director 246-66-3039 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Mactical Examinar must be notified at 1 □Yes 2½ No Director Landover MD Prince Georges 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, the Madical Example must be no once. USA 20785 6413 Country Club Dr. Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: þ Black 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Tricon Construction Laborer 11th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha Carlyle Wiley McCall, Sr. ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4022 Meadow Trail Lane Hyattsville, MD. 20784 Kimberly Ford - daughter altimore, 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery | 10-16-2010 | Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euperal Service Licensee Mar Nama T1 Address of Facility uneral Home of Maryland Suitland, MD. 20746 4308 Suitland Rd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) **Physician** /Medical ue to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine esothe woma Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trai Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 - Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes 24 hours after death.

Funeral Director: After this certific letely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completely fil 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier n Mg D35 H21 10/12/2010

I death (Item 23a) (Type, Print)

210/ East Jefferson St. Rockville, MO 20852

Strar's Signature

State

31. Date filed (Month, Day, Year)

OCT 1 9 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ DORIS ELIZABETH MILLER 1:02am toher Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Plato Civista Medica Charles .CL 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min Month, Day, Year) 9 2 9 1 □ M 2 🔽 F Months 197-20-2973 81 Yrs Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD. CHARLES BEL ALTON 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9603 ORIOLE LANE U.S.A. 20611 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates WHITE Specify: 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOME WOO HOMEMAKER 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ RALPH GEORGE PAULES DOROTHY MAE BROMMER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLES K.MILLER-SPOUSE 9603 ORIOLE LANE BEL ALTON, MD. 20611 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State TROPOLITAN CREMATORY 10-28-1 0 ALEX., VA. Signature of Funeral Service Licens M00479 P. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MARYLAND 20646 at enter the mode of dying, such as cardiac or respiratory arrest. 23a. Part 1. Enter the disease, or complication s that caused the death. Do Approximate . Interval Between shock, or heart failure. List only one se on each line Immediate Cause (Final Onset and Death Physician/ POUR ANGI disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician; The law requires that the death certificate be executed for use as the burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Linknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2No 3 Probably 4 Unknown 1 🗌 Yes page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the nest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 20620

Registrar

State

Name and address of

31. Date filed (Month, Day, Year)

erson who completed cause of death (Item 23a) (Type, Print

32. Registra s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Cert	ificate of		ia montani		∠ U I eg. No.	U 34041
Physici		Decedent's Name (First, Middle,Last)					2. Date of Death Month Day Year		3. Time of Death 0503 hrs
Medical Exami	iner	Brian Walker M 4a. Facility Name (if not institution, give		4b. City, Town, or Location of Death		October 2:	3, 2010 4c. County of 0		
1		4974 Pintail Court		Frederick Frederick					
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Ye			` le	9. Birthplace (State or oreign
Director			1 2□F 53	Yrs		ys Hours Will	06/07	/1957	Country) PA
any	Director	Usual Residence of Decedent 10a. State 10b. County		own or Locati	ion				10d. Inside City Limits
<u> </u>		MD Frederi	ck Fred	derick					1 Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once.		10e. Street and Number			10f. Zip Code			g. Citizen of What	•
ith the 23a or notifie		4974 Pintail Co			21703			nited S	
eath wi items ust be	Funeral	1 X Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No			ispanic Origin? (S in, Mexican, Puert		White, e	American Indian, Black, etc.
after d	by Fu	3 Widowed 4 Divorced		1	Yes 2 N	o specify:		Specify: W	hite
hours 'natur		15. Decedent's Education (Specify only				ation (Give kind of e. DO NOT use re		16b. Kind of Busin	ess/Industry
36 hin 72 e. than "	To Be Completed	Elementary/Secondary (0-12)	College (1-4 or 5+) 5+	Deaf	Interp	reter		Educat	ion
5-00 led wit Hygien other		17. Father's Name (First, Middle, Last)				18.Mother's Nam	e (First, Middle, N		
21215-0036 ruld be filed within 7 Mental Hygiene. marked other than c event, the Medica		Salvatore Micel: 19a. Informant's Name/Relationship (Typ		I 405 Mailin	Addrsss (Ch	Gloria		to City of Town	State 7's Code
AD 2 2 shoul 1 and N 27 is m		Marsha Miceli						ber, City or Town,	State, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition	20b. Pl	ace of Dispos ematory or oth	ition (Name of co	nia, PA	Date	20c. Location - Ci	ty or Town, State
Pages		1 Burial 2 Cremation 3 Donation 5 Other Specify:	Removal from State Smi	thsbu	irg Cre	m. 10/	/27/201	O Smit	hsburg, MD
Salti ermit. Separtn mports njury o		21 Signature of Funeral Service License	1104640	2₹ B	ene and Address	s Basson	d P.A.	Funera	1 Home
Physician	_	MO1612 106 E. Church St., Frederick, MD 21701 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva							
/Medical		failure. List only one cause on each line. Between Onset and Immediate Cause (Final disease a. Atherosclerotic cardiovascular disease							
Examiner			ie to (or as a consequence of):		z d zo v abc	didi dibe	-450		
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):							
	amine	cause. Enter Underlying Cause (Disease or injury that initiated							
uted od ansit	Ш	events resulting in death) Last d.	ie to (or as a consequence or):						
'60, ate be executed obysician and ne burial - trans	Medical	XUNPENDED AMENDED AMENDED 23a,PII,27,per mE g910 12/13/10 TT							
760, ficate be ex g physician the burial	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregna	incy				23d. Date of de Month	livery Day Year
Box 687 death certific the attending p	iciar	past 12 months?	4 Pregnant at time of deat	_ = =	tal death 3 ner (Specify)		ancy	World	Day Teal
. Bo he dear y the at	Physician/	Part II. Other significant conditions	9 Unknown	ulting in the u	ndorlying course	given in Bart I	23e Did to	bacco use contribut	to to the cause of death?
, P.O.	2	Lung disease						Probably 4 Unknown	
rds, require been si	Completed	-					24a. Was a		re autopsy findings available r to completion of cause of
Division of Vital Records, tal or Attending Physician: The law requir is after death. al Director: After this certificate has been seen in by the funeral director, page 2 should the fine or the funeral director.	дшс	autopsy prior to complet performed? death? 1 Yes 2 V No 1 Yes							th?
tal Rection: The certificate ector, page	Be C	25. Was case referred to medical examiner?			26.Plac	e of Death (Check			
f Vit Physic or this c	10	1 Yes 2 No 27. Manner of Death		R/Outpatient				Residence 6 🗸	Other: Scene
ion of tending Pl eath. or: After the funera	ion:	Natural 5 Pending	28a. Date of Injury (Month, Day,Year)	28b. Time of Ir		ury at Work? Yes 2 No	Zod. Describe n	ow injury occurred	
/iSiC r Atte ter dea irecto	ficat	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At hom	ne, farm, stree	et, factory, office	building, etc.			or Rural Route Number, City
Div spital o	Certification:	4 Homicide determined (Specify)							
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as the state of t		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)							
Tot with Tot	Medical	29b _a Signature and title of certifier	nd manner stated.		29c. Licen		, ,		(Month, Day, Year)
		Mario Dre	Krell-		O.C.	M.E.		October 24, 2	2010
		30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2120							
	2/2	Margarita Korell MD. Assi 31. Date filed (Month, Day, Year)	stant Medical Examine 32. Registrar's Signature		enn Street, E	saitimore, MD	21201		
Regist		NOV 0 4 20	10 Mesoura	A. 100	arked		, a.		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October James E. Nowland 2010 05:28a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death E1kton Union Hospital Cecil | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Hours | Min. | May 10, Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □XM 2 □ F Director 217-20-3669 84 MD Usual Residence of Decedent , or items 23a or 28a-f show uniner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 ☐ Yes 2 √ No MD Cecil Rising Sun 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 181 Calvary Lane 21911 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Xyes 2 No If Yes, Give "natural", or item ledical Examiner ח Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: 3 Widowed 4 Divorced White Year or Dates. al Hygiene. I other than "nature vent, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Operator State Highway Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Emma Wallace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara McKnight/ daughter 181 Calvary Lane Rising Sun, MD 21911 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 10/2372010 ☐ Burial 2 ACremation 3 ☐ Removal from State R.T. Foard Funeral Home, P.A. 4 ☐ Donation 5 ☐ Other (Specify) Rising Sun, MD 22. Name and Address of Facility R.T. Foard Fune . Si ure of Juneral Service Licensee T. Foard Funeral Home, P.A. 9 E. Main St. Elkton, MD 21921 and Part 1/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a. Part 1/ Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): nding physician and use as the burial-transit Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth
Pregnant
Unknown for 1 in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò page 2 should be Completed 1 Yes 2 No 3 Probably 4 Onknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 ☐ Yes 2 ☐ No Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? Investigation
6 Could not be 1 Yes 2 No Accident

or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di To the Hospital

Registrar

State

Medical

Suicide

29b. Signature and title of certifier

determined

4 Homicide

29a. Certifier

10Ce

completed cause of death (Item 23a) (Type, Print)

Ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Definition of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner:

the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ p_M 2010 Neifert 10 06 Eugenia Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges 4209 51st Street **Bladensburg** If Under Hours 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, Funeral 1 □ M 2 🛣 F Months Min. 03/24/1916 Country) Alabama Director 94 214-16-4165 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 X Yes 2 □ No Prince Georges MD Bladensburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4209 51st Street 20710 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 2 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: "natural", Completed 3 Widowed 4 K Divorced White event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) <u>Admini</u>strative Assistant 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Carobel Glover Robert H. McDonald other traumatic t. Page 1 and 2 show.
To f Health and Mr.
To 77 is m. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2438 Rippling Brook Road Frederick, MD 21701 Robert Burch - POA Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/01/2010 Arlington, VA Arlington Nat'l Cem 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ft. Lincoln Funeral Home, long Montgomens 3401 Bladensburg Road Brentwood, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ disease or condition resulting in death) End Stage Dementia Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Examine Due to (or as a consequence of) physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical certificate be P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Month Day Year Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Abnormal Weight Loss Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has performed? Yes 2 No 2 🗌 No 1 Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificated filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 noindent Property Residence 6 <math>
noindent Description2 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending Natural work? 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10/8/10 D0038 013 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6525 Belcrest Rd., Hanadi Shamkani, MDHyattsville, MD 20782 32. Registrar's Signature 31. Date filed (Month, Day, Yea, State OCT 1 9 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2010 Physician/ Oct. John M. Owen 9:15 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George's Sacred Heart Nursing Home Hyattsville If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth 6. Sex **Funeral** (Month, Day, Months Days Hours Min. 11 M 2 D F Woodsdale, Director 577-09-8762 97 Nov. Usual Residence of Decedent 28a-f shov iral", or items 23a or 28a-f shor Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director MD Prince George's Mt. Rainier ₩ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4007 30th Street 20712 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 14. Race - American Indian Black, White, etc. <u>م</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White "natural", 3 X Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Accountant Financial other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H Joseph Owen Vergia Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mit. Page 1 and 2 sh partment of Health ar portant: If item 27 is y injury or other trau John M. Owen, Jr. - Son 4007 30th Street, Mt. Rainier, MD 20712 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Department or Important: If any injury or Gate of Heaven Cemetery 10/19/10 Silver Spring, MD 4 Donation 5 Other (Specify) 21. Signature Mineral Service Licenses 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Gasch's Funeral Home, P.A. F. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician Hypertensive Cardiovascular Disease disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Coronary Atherosclerotic Cardiovascular Disease Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami that initiated events resulting in death) Last Due to (or as a consequence of) ending physician a use as the burial-Physician/Medical death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atter for u in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death ☐ Yes 2 L ☐ Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Progressive Cognitive Decline 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? Dementia, Alzheimers 24a. Was an has page 2 autopsy performed? Yes 2 N To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 2 No 1 🗌 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Tes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

State Registrar 29a. Certifier

29b. Signature and title of certifier

30. Name and address of person w

Esmerando O. MD 1160 Varnum St. NE, #008, Washington, DC 20017 Juan1tez 31. Date filed (Month, Day, Year) 32. Registrar's Sign OCT 2 0 2010

se of death (Item 23a) (Type, Print)

1 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D051122

29d. Date signed (Month, Day, Year)

10/15/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 2010 4:15 P. October Anabe1 Perez Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death Examiner Rockville Montgomery Shady Grove Adventist Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number Month, Day, Year) 1 1959 **Funeral** New York 1 □ M 2 🕱 F 51 Director July 111-54-5483 Usual Residence of Decedent 28a-f shov 10b. County 10c. City. Town or Location 10d, Inside City Limits 10a State death with the Maryland Director Examiner must be notified 1 Yes 2 X No Marvland Silver Spring Montgomery 10g, Citizen of What Country? 10f. Zip Code 5 10e. Street and Numbe Funeral items 23a 20906 United States 14227 Grand Pre Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? 5 þ 1 X Never Married 2 Married 1 K Yes 2 □ No Specify: Puerto Rican 72 hours after If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene Important if item 27 is marked other than any injury or other traumatic event, the Meonce. Elementary/Seconday (0-12) College (1-4 or 5+) Health Care Primary Care Coordinator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျှ Aida Fitzpatrick Celestino Perez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12546 Cross Ridge Way, Germantown, Maryland 20874 Lydia Ramirez/Sister 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 10/22/2010 | Alexandria, Virginia Metropolitan Crem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenst 22. Name and Address of Facility DeVol Funeral Home MO1116 20877 10 East Deer Park Dr., Gaithersburg, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 10mg disease or condition Medical resulting in death) s a consequence of) Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): e attending physician and ما المرابعة والمرابعة المرابعة To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innerial director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2. No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ျပ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work?
1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 20a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) to completed cause of death (Item 23a) (Type, Print)
WWKL G707 MoChal Date filed (Month, Day State Registrar

2010

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Maryland 2121

Baltimore,

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Joan Carol Palfi October 13,2010 2108P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Olney Montgomery Social Security Number 8. Date of Birth (Month, Day, Jan . 22, 9. Birthplace (State or Foreign Country) New York If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) Days Hours 1 M 2 **Director** 152-28-3658 72 Usual Residence of Decedent or 28a-f shov filed within 72 hours after death with the Maryland 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 🗌 Yes 2 📕 No Maryland Montgomery Woodbine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3275 Florence Road 21797 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes If Yes, Give 2 No 1 ☐ Yes 2 ■ No Specify: ^{Specify:} White "natural", 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Mediconce. 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Stephanowitz Jean Zomro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan A. Palfi/ Daughter 3275 Florence Road, Woodbine, MD 21797 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oct. 18,2010 Marriottsville, Maryland Crestlawn Mem. Park 22. Name and Address of Facility
Molesworth-Williams, P.A., Funeral Home
26401 Ridge Road, Damascus, MD 20872 21. Signature of general Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ YOCK-dia disease or condition resulting in death) de Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or). To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director; After this funeral (27. Manner_of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending 1 🗆 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certi D0055694 YSICIAS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Yea

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MATHUR

32. Registrar's Signature

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Olzey-Leyfercule Red Oney, MD 20532

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

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	•	State Registrar					Certii	ficate	of E	eath			Reg. I	vo.2 N	10	31.61.7
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Physicia Medic		Marie Sug									_	Month Oc tob	er 1	3, 201	.0	12:30 a M
Examin	er	4a. Facility Name (if Holy Cros		n, give street and nun :tal	nber)		4	-		Location of pring			4c. County of Death Mon topmery			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 6 5 may niquy or other traumatic event, the Medical Examiner must be notified at 6 0 0 0 000ce.		5. Social Security No. 213–38–114		s. last birthd 72 Yr	-77 N	If Under Months	1 Year Days	If Under Hours	8. Date of Bi (Month, Da July 27				thplace (State or Foreign untry) MI			
	L	Usual Residence of 10a. State	Decedent 10b. County		100										10d. Inside City Limits	
	ecto	MD			100.	10c. City, Town or Location										1 🗆 Yes 2 😾 No
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nd 2 should salth and N n 27 is ma er trauma		19a. Informant's Name/Relationship (<i>Type, Print</i>) Lisa P. McCarl/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 44 Apple Blosson Lane, Charles Town, WV 25414											Code)			
Page 1 an nent of He ant: If iten ury or oth	(0)	20a. Method of Disposition 1														
permit. Departr Imports any inji		21. Signature of Fur	neral Service I	Licensee Cole			환합 500	lame and INCIS Unive	Addres ersit	oiin y Blw	Fun	eral Home , Silver	Inc Spri	ing, MD	2090	01
Physician/		23a. Part 1. Enter the shock, or hear Immediate Cause (rt failure.List	om lications that con one cause on ea	ch line.			he mode	of dying	j, such as	cardiac	or respiratory a	rrest,			Approximate Interval Between Onset and Death
Medical		disease or condition resulting in death)	n	a	. -Organ (or as a cons										-	
Examiner	Ļ	Sequentially list con	nditions.	b. —	nant He			ıre								
executed ian and urial-transit	Examiner	if any, leading to im cause. Enter Under Cause (Disease or that initiated events	imediate rlying iinjury	oras a cons ole Unde	equence on. erlying	Cano	cer of	Unk	nown (Origi	n					
9 F 75		resulting in death) L	Last	Due to	(or as a consequence of):											
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	nonths?										ivery Day Year		
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equire een si nould	eted											4				robably 4 🔀 Unknown
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sian; ertifica ector, I	Be (25. Was case referre	ed to medical	11. 2.1					26. Pla	ce of Dea	th <i>(Chec</i>	k only one)	- 7			
Physicathis call dire	မ	1 🗆 Yes 2 🗔	X No		Inpatient 2	7				4 ∐ Nı	ursing Ho	ome 5 🗆 Resi				ify)
ending F eath. or: After i he funera	Certificate:	27. Manner of Death 1 X Natural 2 Accident	5 Pendir	gation	of injury th, Day, Year)	28b. Tim inju	ıry	M 28	c. Injury work?		No	28d. Describe	how inj	ury occurr	ed	
ital or Att urs after d ral Direct		3 ☐ Suicide 4 ☐ Homicide	6 ∐ Could determ	nined 28e. Place buildi	of Injury - At ng, etc. (Spe	cify)						City or To	tion (Street and Number or Rural Route Number, or Town, State)			
he Hosp in 24 hou he Funei pleted fil	Medical	(Check 2	Medical E	g Physician: To the b Examiner: On the bas g Nurse Practioner:	is of examina	tion and/or ir	nvestiga	tion, in m	y opinio	n, death oc	ccurred a	t the time, date	and plac	ce, and due	e to the c	cause(s) and manner stated.
with voint		29b. Signature and t	title of certifie	Atu				29c. License number D64100					29d. Date signed (Month, Day, Year) Oct. 13, 2010			
				who completed caus	,			*	Cum	inc "	ID 200	210				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death PEEBLES Physician/ Month BETTY 4:53 P M 2010 O CTORES Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hospital RANDAUSTOWN BALTIMORE NORTHWEST 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** $OCT^{Month, Day,}$ 1 □ M 2 🛛 F Days Hours Country) Months DC Director 76 577-44-8379 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2X No PRINCE GEORGES MITCHELLVILLE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a 20721 11900 PLEASANT PROSPECT RD. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. ò ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates Specify: "natural" Completed 3 X Widowed 4 Divorced BLACK Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working filed within 72 tal Hygiene. d other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the MINISTRY 5+ SENIOR PASTOR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, should be file h and Mental F 7 is marked o မ DOLLY POINDEXTER ROY POINDEXTER traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. MITCHELLVILLE, MD. 20721 12008 SHADYSTONE TERR. JOEL R. PEEBLES - SON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) X Burial 2 Cremation 3 Removal from State HARMONY MEMORIAL PARK 10-22-2010 4 ☐ Donation 5 ☐ Other (Specify) LANDOVER, MD 21. Signature of Euneral Service Licenses MARYLAND iclarino 4308 SUITLAND RD. SUITLAND, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PHEUMONIA ASPIRATION disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner LEUS Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury burial-transif COLON CANCER that initiated events Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by URINARY Division of Vital Records, TRACT INFECTION 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? BLADDER CANCER 24a. Was an has autopsy certificate ha 2 No Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospita 1 Yes 2 No Other: မ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: al or Attending F s after death. I Director: After 1 X Natural 5 Pending 1 Yes 2 No Investigation Accident completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral D Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying No. ctioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) D0060293 OCTOBER 12, 2010 erson who completed cause of death (Item 23a) (Type, Print) COURT ROAD. RANDALLSTOWN, MD

DHMH 17 Rev 7/2009

State Registrar

MURTU24 31. Date filed (Month, Day OLD

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AHMED, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ MUND OLCIAM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORP If Under 24 Hrs 8. Date of Birth (Month, Day, Ye August 24, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 **Funeral** 1 🏻 M 2 🗆 F Months Days Hours Cheverly, MD 38 214-82-7801 1972 Director Usual Residence of Decedent or 28a-f show notified at show 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 X Yes 2 No College Park Prince George's Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ò must be r Funeral USA 9626 51st Place 20740 items? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14, Race - American Indian, "natural", or iter edical Examiner Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. ۵ 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Assembler Private Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) i. Page 1 and 2 should be filed tment of Health and Mental Hi tant; If item 27 is marked out ijury or other traumatic even Johanna Phillips Raymond H. Peacock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9626 51st Place, College Park, MD 20740 Johanna Mullen / Mother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Department of Important; If it any injury or c 1 X Burial 2 Cremation 3 Removal from State 10/14/2010 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 22. Name and Address of Facility Signature of Funeral Service Licenses 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final Physician IPARS disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any leading to immediate Examine Due to (or as a consequence of cause. Enter Underlying Cause (Disease or linjury that the death certificate be executed the burial-trans and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 use as t IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? for Year Month Day Pregnant at time of death 2 No 1 ☐ Yes 2 ☐ Unknown 9 Unknown detached P.O. ģ been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIOMYOPATHY Hospital or Attending Physician: The law requires Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 2 No 1 Yes Yes 2 **Division of Vital** funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 - No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work?
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Registrar

2 0 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $10^{\rm th}$ Physician/ 20 jeg Clarence Peterson 7:43 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Clinton Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec. 19 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 K M 2 🗆 F Months Days Hours Min. 372-24-1727 Michigan Director Dec 1928 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits must be notified at Director Prince George's Upper Marlboro MD 1XX Yes 2 No 10f. Zip Code 9 10e. Street and Number 10g. Citizen of What Country? 23a20772 USA 5815 S. Marwood Blvd. items 12. Was Decedent Ever in U.S.
Armed Forces?

1 X Yes 2 No 1954 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Medical Examiner Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify Specify: Black "natural", Completed 3 Midowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 1 and 2 should be filed within 72 f Health and Mental Hygiene. item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) the Civil Servant Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lenora Wilson Thomas Huge Peterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11507 Old Lottsford Road Mitchellville, MD 20721 Fay Peterson/Daughter injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot Burial 2 Cremation 3 Removal from State 10/20/2010 Clinton, MD 4 Donation 5 Other (Specify) Resurrection Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Marshall-March Funeral Home 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exam use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical P.O. Box 68760 s been signed by the attending should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Unknown 1 L Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performe certificate has To the Hospital or Attending Physician: The I within 24 hours after death.
To the Funeral Director: After this certificate h **Division of Vital** completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Yes 2 No 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

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2039

10-08265 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 010 34651 Anthony Patterson, Jr. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month Day October 29, 2010 **Medical Examiner** 0710 hrs Patterson, 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Washington Washinghton County Hospital Hagerstown If Under 1 Year I If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) Country) Months Days Director 213-89-2980 1XM 2 F 13 16, 2010 Maryland Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City. Town or Location 1 X Yes 2 No 28a-f show permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important. If I item 27 is marked other than "astural", or items 23s or 28s-f sho injury or other traumatic versit, the Medical E. suminer must be notified at once. Washington Director Hagerstown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1005H Noland Dr 21740 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 X Never Married 2 Married 2 X No Yes Specify: Bi Racial 4 Divorced f Yes, Give Year 1 Yes 2 X No specify: ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Tammy Eichelberger Anthony Patterson, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1005H Noland Dr., Hagerstown, MD Anthony Patterson, Sr./Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 11/2/2010 Hagerstown, MD Rest Haven Cemetery 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licensee S. Mark Su 1601 Pennsylvania Ave., Hagerstown, Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a Aspiration of milk Immediate Cause (Final disease **∤xamine**r or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and tran wsician/Medical X UNPENDED AMENDED 3a,27,28a-f, per ME g910 12/16/10 TT the attending physician red for use as the burial -Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Fetal death Ectopic pregnancy Year Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been subneral director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? ✓ Yes 2 No 1 🗸 Yes Hospital or Attending Physician: 24 hours after death 25. Was case referred to medical 26.Place of Death (Check only one) Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other 1 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural subject aspirated on milk 5 Pending 1 Yes 2 X No Director: d in by the f 2 X Accident 10/29/10 Fd 6:20 am 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) $1005\ Noland\ Dr$ Hagerstown, MD 3 6 Could not be Suicide residence (Specify) Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the I within 2. To the I 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 30, 2010

Registrar
DHMH 17 Rev 1/2001

State

111 Penn Street, Baltimore, MD 21201

ank

30. Name and address of person who completed cause of death (Item 23a)

Deputy Chief Medical Examiner

32. Registrar's Signature

Mary G. Ripple MD.

31. Date filed (Month, Day, Year)

Division of Vital Records,

To the Hospital or Attending Physician: The law requires that the death certificate be executed this After t within 24 hours after death.

To the Funeral Director: Α completely filled in by the fu

Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manne of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29d. Date signed (Month, Day, Year)

October 14, 2010

39813

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

- 201 Hall Highway - Crisfield, MD Michael Atkins, MD 21817

State Registrar 32. Registrar's Signature

31. Date filed (Month, Day, Year) OCT 1 5 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra MEND#24bperMD, 10/18/10, BWW, MbCo Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month **Physician** tober 8,2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore City **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number 7 Age (In vrs. last birthday) Funeral Days EI Salvador 1 🔀 M 2 🗆 F 578-13-9638 48 Nov. 13, 1961 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 1 ☐ Yes 2 X No Director MD Montgomery 01ney 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code United States 20832 18121 Bilney Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after Hygiene. 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 XNo Salvadorian Other Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: à 3 Widowed 4 Divorced "natural". Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) is marked other than Real Estate Property Investor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Antonio Esperanza Romero Juana Ayala 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 18121 Bilney Dr., Olney, MD 20832 Maria J.H. Romero, Spouse 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 20a. Method of Disposition cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemet 10/14/10 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simple Tribute M01463 Rockville Pike, Rockville, MD 20852 1040 23a. Part 1. Exist the discussion as as a cardiac or respiratory arrest, shock, it learn failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate La se (First disease or condition resulting in death) **Physician** Cardiopulmonary /Medical Due to (or as a consequence of Examiner Preumonia Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Life to (or as a consequence of) Burial-transit SEPSIS death certificate be executed and Due to (or as a consequence of) resulting in death) Last g physician a promised due to lune, transplan Box 68760. Physician/Medical the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Dav in the past 12 months?
1 ☐ Yes 2 ☐ No for Pregnant at time of death 5 Other (specify) Unknown of Vital Records, P.O. signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ ate has been signer page 2 should be a 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 X No 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2XN0 Other: 4 \sum Nursing Home Hospital: 1 Inpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) ၉ this 28c. Injury at Work? filled in by the funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of To the Hospital or Attending Pr within 24 hours after death.

To the Funeral Director; After th completely filled in by the funeral 27. Manner of Death Certification: Division Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number October 8,2010 RES-DOD 5 address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 JALA

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

OCT 1 4 2010

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 16, Day 2010 Mario Rene Ruiz 10:00 a М Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 12613 Gould Road Silver Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Jan. 27, Birthplace (State or Foreign Country)
 Cuba Funeral 6. Sex 7. Age (In yrs. last birthday, Days 1 **₹** M 2 □ F Months 1935 217-94-3176 75 Director Yrs Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12613 Gould Road 20906 LISA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 😾 Married Baltimore, Maryland 21215-0036 Yes 2 TrNo 1 ★ Yes 2 No Specify: Cuban If Yes, Give Year or Dates. White Specify Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self-Employed Watch Repair Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Miquel Angel Ruiz Cira Yanes Borges 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raisa Ruiz/Wife 12613 Gould Road, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Oct. 19 1 Burial 2 Cremation 3 Removal from State Metropolitan Crematory Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 2010 Signature of Funeral Service Licenses 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Fuysician/ Stroke Medical Due to (or as a consequence of): Examiner Atrial Fibrillation Sequentially list conditions, if any, leading to immediate cause. Force Incorping Due to (or as a consequence of): Exami Cause (Disease or iinjury burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) Pregnant at time of death 5 Other (specify) Month Day Year 4 ☐ Pregnam 9 ☐ Unknown signed by the a 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes Mellitus, Hypertension, Hypercholesterolemia 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate has 1 Tyes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No director, Be 26. Place of Death (Check only one) Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1X Natural 5 Pending Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 To the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10810 Connecticut Avenue, Kensington, MD 20895 Robet Trimble, Md

State

Registrar

Registrar's Signature

OCT 1 9 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State 10-26-10 Registrar Amend#10e.19b.PerInformentPCCcr Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Ernest L. Robinson, Jr. ZOID 18:00 M 10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MANDRIN HOUSE HOSPICE CHESAPEAN HARWOOD ANNE ARUNDEL . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months 578-78-4668 1 ★ M 2 □ F 3 Min 09-06-1957 5 Washington, DC Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location the Maryland traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Prince CHELTENHAM MD 1 Yes 2 No UBDIGES 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral 9908 USA 23a Drive ungova items Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married marked other than "natural", or Completed by 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2XXNo Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than Government Graphic Designer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ MINOR KUBINSON GERAUDINE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number, or Rural Route Number, City or Town, State, Zip Code) BIBENADUTE RUBINSON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, injury 4 ☐ Donation 5 ☐ Other (Specify) MISHORISE CAM 10.23.10 21. Signature of Funeral Service License 22. Name and Address of Facility Bianchi 814 Upshur St NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, il any, leading to in mack cause. Enter Underlying Cause (Disease or iinjury Due to lor as a consequence of: or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) Year 4 ☐ Pregnant 9 ☐ Unknown the detached 9 Unknown ò is certificate has been signed director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by 1 🗌 Yes 2 🗖 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Yes 2 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 No To the Hospital or Attending Physical within 24 hours after death.

To the Funeral Director: After this a completed filled in by the funeral director. 1 Inpatient 2 ER/Outpatient 3 DOA 4
Nursing Home 5 Residence 6 Other (Specify this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 A Natural
2 Accident
3 Suicide
4 Homicide work? injury 5 Pending 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical Letrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medica! Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29d. Date signed (Month) Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Shelby Wayne Robertson 9:50 Ам October Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Montgomery Silver Spring 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth **Funeral** 1 ፟ M 2 □ F Hours Min December 5, 1932 Months 230-36-4985 77 Pemberton, WV Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Prince George's College Park Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20740 USA 9518 49th Avenue "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status rmed Forces Black, White, etc. þ 1 Never Married 2 X Married 2 🗌 No Maryland 21215-0036 If Yes, Give Year or Dates. 1953–1955 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Pile Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Curtis Robertson Maggie M. Fritz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9518 49th Avenue, College Park, MD 20740 Dorothy Mae Robertson / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 10/18/2010 Alexandria, Virginia 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 2 RAN 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Pnysician/ a Aspiration Pneumonia Weeks disease or condition Medical resulting in death) Examiner Left CVA Weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death sate has been signed by the a page 2 should be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Seizure Disorder, Prior Stroke Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ♣No 24a. Was an autopsy performed? Yes 2 AN certificate 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 \(\triangle \text{ Nursing Home } 5 \) Residence 6 \(\triangle \text{ Other (Specify)} \) 1 🗆 Yes 2 1 No Certificate: To 1 ► Inpatient 2 □ ER/Outpatient 3 □ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No Investigation Accident

To the Hospital

8+1

State Registrar

Medical

Suicide

3 🗆

OCT 2 0 2010

4 Homicide

only one) 29b. Signature and title of certifier

29a. Certifier

6 Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barbara Ann Supanich, 1500 Forest Glen Road, Silver Spring, MD 20910 31. Date filed (Month, Day, Year 32. Registra s Signa

sanich

DHMH 17 Rev 7/2009

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

📂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

28f. Location (Street and Number or Rural Route Number.

29d. Date signed (Month. Day, Year)

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of M	arylan				ealth a			Reg. No	0 1 0	346	
1	Physici		Decedent's Name (First, Middle, La KEITH REID	ist)							Month ctober	Da	y 2010	r	
	/Medic Examir		4a. Facility Name (If not institution, gire	ve street and number,)		4b. Cit	, Town, or	Location o		CLODEI		. County of De		A
*	Exam	90	PRINCE GEORGE'S	HOSPITAL (CENTE	R	СН	EVERI	Υ			PR	INCE G	EORGE'S	
	Funeral Director			Sex 7. A(1 M 2 □ F	ge (In yrs. 54	last birthday) Yrs.	If Und Months	er 1 Year Days	If Under 2 Hours	Min.	B. Date of Bir (Month, Da 1/22/1	th y, Year) 956		irthplace (State Country) shingto	
	land ow		10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside	City Limits
	Many a-f sh	tor	Maryland Prince	George's		Adelph	i							1 ∑ Ye	s 2 No
	or 284	Director	10e. Street and Number		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	•		ip Code				10g. Cit	tizen of What	Country?	
	ath w	rai	1836 Metzerott R									Uni		tates	
36	72 hours after death with the Maryland "naturel", or items 23s or 28s-f show salical Examinatings the notified at	by Funerai	11. Marital Status 1 2 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🛣No			Nas Decedent of Hispanic Origin? (Specify Yes or No IYes, specify Cuban, Mexican, Puerlo Rican, etc.) I □ Yes 2[x] No Specify:						Specify:		
9	n 72 hou	ted	15. Decedent's E	ducation		16a. Dece	dent's Us	ual Occup	ation			16b. K	ind of Busines	31ack ss/Industry	
21215-0036		Completed	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT	use retired	during most)	or working	9				
21	D 70 =		12			Di	rect	Care	Aide		(e ^m		rivate		
and	d la b y	Be	17. Father's Name (First, Middle, Las Wilmer Reid	t)				İ			(First, Middle, na Wils		Sumame)		
7	should nd Men marke imatic	ပို	19a. Informant's Name/Relationship	(Type Print)		10h Maili	ng Addro	es (Street					or Town, State	Zin Code)	
re, Maryland	1 and 2 Health a bm 27 ie ther trau		Vincent Reid / E	Brother	1 6	1	0 Ye	11ow	Pop1a		. Bran	dywi	ne, Ma	ryland or Town, State	20613
Ē	nit. Pages partment of I cortant: If its injury or or		1 Burial 2 Toremation 3 4 Donation 5 Other (Special		'	tropo1	-			0/15	/2010	Ale	xandri	a, VA	
Baltimore,	permit. Par Departmen important: any injury once.		21. Signature of Funeral Service Lice Charles E. 1	bem	n009	5	538	Mar1b	oro P	Pope Pike	Funer: Forest	al H vill	lomes,		0747
	Physician /Medical Examiner		23a. Part1. Enter the disease, or for shock, or heart failure. List(opt) Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. SEPSI: Due to (or as	S s a conseq ISEAS	uence of):	ter the mi	ode of dyin	g, such as	cardiac or	respiratory a	rrest,		Approxim Interval B Onset and	etween
	sit sq	iner	cause. Enter Underlying	Due to or as	s a conseq	uence of									
	be executed icien and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. AIDS Due to (or as a consequence of):											
760,	e X e	ical E			CORY FAILURE										
P.O. Box 68	death certifica e attending ph od for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta at time of d	I déath 3 [eath 5 [Other (23d. Date of o	delivery Day	Year
	uires tha signed Id be det	þ	Part II. Other significant conditions	contributing to death	but not res	ulting in the u	nderlying	cause giv	en in Part I.				use contribute	to the cause of Probably 4X	f death?]Unknown
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Ϋ́	S 0 10	To B	examiner? 1 \(\text{Yes} \) Yes \(\text{Y} \) No	Hospital: 1 XInpat	ient 2 🗆	ER/Outpatier	nt 3 🗆 [Oth Oth	or				6 □Other (S)	pecify)	
ion of	fing After fune		27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation			28b. Time o Injury	f M	28c. Injur Wor	yat k? Yes 2 □ l		8d. Describe	how inju	ry occurred		
Division	in the	Certification:	3 Suicide 6 Could not 4 Homicide determined	building, e	tc. (Specif	y) 					City or To	wn, Stat	e)	Rural Route Nu	imber,
	o the Hospital or thin 24 hours after the Funeral Dir mpletely filled in	edicai	29a. Certifier 1 🛣 Certifying P (Check only 2 🗌 Medical Exa	hysician: To the bes miner: On the basis and manner s	of examina	wledge, deat tion and/or in	h occurre vestigation	d at the tin	ne, date an pinion, deal	d place, ar th occurre	nd due to the d at the time,	cause(s date an	and manner d place, and d	as stated. lue to the cause	e(s)
	To th withir To th comp	Me	29b. Signature and the of certifier	7 .			2	9c. Licens	e number			29d. Da	ate signed (Mo	onth, Day, Year)	
1	'n		Jull les	m-				275	77			10	112/1	Ü	
	4		30. Name and address of person who					nita	1 Dw4	VA CL	ever1.	, M	arvlan	1 20785	
÷	Sta	to	Ophnell Alfred C	32. Rais	trar' Sieca		r no:	phrra	T DIT	ve GI	ieverty	, 11	агутан	20/03	
4	Registi		OCT 2 0 2010 A	32. Regist	1900	,									

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Clarence Henry Stewart 00t.9.2010 0602 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In vrs. last hirthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Davs Hours (Month, Day, Director ີ 1/931 Wash. 579-40-6574 78 Usual Residence of Decedent 28a-f shov 10b. County wermit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD Silver Spring Montgomery 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 9109 Second Avenue 20910 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?
1 ☑ Yes 2 ☐ No 1950 Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: Black Completed 3 Widowed 4 Divorced 1954 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor U.S.Post Office Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Douglass Stewart Ethel Soreng Blackwell 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda Whiteside/Daughter 8609 Geren Road Silver Spring, Md. 20901 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗆 Burial 2 🕱 Cremation 3 🗆 Removal from State cemetery, crematory or other place Chesapeake Crem. 10/16/2010 Beltsville, Md. 4 Donation 5 Other (Specify) uneral Service Ligen 21. Signature PHILIPHOLOGICAL SERVICE, P.A. Columbia Blvd.Silver Spring.Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final -Physician/ Acute myocardial infarction
Due to (or as a consequence of): Medical resulting in death) Examiner End stage renal disease Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or iinjury Generalized arteriosclerosis 20yr. Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a q ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≦ malignant neoplasm prostate 1 Yes 2 No 3 Probably 4 Unknown Completed cate has been s page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 N After this certificate funeral director, pag 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 🔀 No ျ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred 1 XNatural iniury 5 Pending death. 2 Accident
3 Suicide
4 Homicide hours a er decth Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ determined 24 hours a Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. pleted 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D004814 Oct.11,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1629 Columbia Rd. NW Washington, DC 20009 E. Vaughn Belton M.D.

State Registrar 31. Date filed (Month, Day, Year,

OCT 20 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10 2010 1940 р 21 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Garrett County Memorial Hospital Oakland Garrett If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2□ F Months Days Hours Min. 215-26-7146 Director 80 28 1930 MD Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b County ns 23a or 28a-f show must be notified at 1 ☐ Yes 2X No Director MD Garrett 0akland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 215 Fingerboard Road 21550 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. th and Mental Hygiene. 7 Is marked other than "natural", or item traumatic event, I'm Medic II Evanting. 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☑ Married altimore, Maryland 21215-0036 If Yes, Give 1.951-1953 1 ☐Yes 2 No Specify Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Hospital Aide Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elmer Shaffer Julie Lantz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Shaffer - wife Health a 215 Fingerboard Road, Oakland, MD 21550 permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tri 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/23/2010 Aurora Cemetery Aurora, WV 22. Name and Address of Facility David A. Burdock Funeral Home P.A. 2nd St, N. Oakland, MD 21550 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. o not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐No ed by the a 9 Unknown been signed tehould be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has After this certificate 2 1 1 ☐ Yes 24 hours after death, structures after descrific structures of the funeral director, etely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Pesidence} \) Residence \(6 \) Other (Specify) 2 No 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Mann Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. within 2 To the 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

32 Registrar's Signature

OCT 27

Saurpoules

30. Name and address of person who completed

ause of death (Item 23a) (Type, Print)

255 N Fourth

54

Cakland

Swite 1

21530

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middler Last) Day Month. UCtoberRo **Physician** .2010 21 /Medical 4c. County of Death 4b. City, Town, or Location of Death a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs.

Months | Davs | Hours | Min. 8. Date of Birth (Month, Day, Year) Dec 21 1954 Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 XM 2 ☐ F **Funeral** Days 55 Wilmington, DE 221-36-7545 Director Usual Residence of Decedent 10d. Inside City Limits or 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2X No Director DE **New Castle** Hockessin 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number ō Pages 1 and 2 should be filed within 72 hours after death with must be 23a 19707 1015 Benge Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 0 White Maryland 21215-0036 1 Yes 2 No Specify: Specify þ 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) **5+** Director Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ith and Mental F 27 is marked of traumatic ever Mary L. Kellagher Walter Joseph Sincoskie 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a 1015 Benge Road Hockessin, DE 19707 Jo Ann Sincoskie other 1 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 🖟 Cremation 3 🕍 Removal from State 20b. Place of Disposition (Name of Hockessin Crematory 10/26/2010 ₽ Department of Important: If any Injury or once. ± 5 4 Donation 5 Other (Specify) Hockessin, Delaware 22. Name and Address of Facility
Chandler Funeral Home
2506 Concord Pike Wi 21. Signatur of Fineral Service Licenses Wilmington, DE 19803 n. part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Onset and Death in the late Cause (Final disease or condition resulting in death) **Physician** Due to (or a a consequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed g physician and as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use as attending IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Day in the past 12 months? Pregnant at time of death 5 Other (specify) Yes 2 No the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) Hospital: 2 No 1 Inpatient 1 Yes 2 ER/Outpatient 3 🗌 DOA မ 24 hours after death.

Funeral Director: After this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending investigation Injury 1 Nes 2 No 2 Accident Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 29a. Certifier (check only 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001

State

30. Name and address of persop

31. Date filed (Month, Day, Year)

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no completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

18826

October 20, 2010

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-07883 State of Maryland / Department of Health and Mental Hygiene Michael Eston Santana Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 0120 hrs Medical Examine October 14, 2010 Santana Michael Ε. 4c. County of Death 4b City Town or Location of Death 4a. Facility Name (if not institution, give street and number) Frederick Jefferson 4411 Gene Hemp Road 9. Birthplace (State or 8. Date of Birth (MM/DD/YYYY) If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** reign Country) Mary Land Months Davs Hours April 30,1987 Director 23 1 X M 2 F 220-33-6918 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No 28a-f show Jefferson Frederick es I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

If item 27 is marked other than "natural", or items 23a or 28a-f she ther traumatic event, the Medical Examiner must be notified at once Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21755 4411 Gene Hemp Road 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 2 X No Yes White 1 Yes 2 No specify: Specify 3 Widowed 4 Divorced If Yes, Give Year \$ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Construction Baltimore, MD 21215-0036 Manager 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Phyllis Allen Walter Santana 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4411 Gene Hemp Rd., Jefferson, MD 21755 Walter Santana / Father Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery 20a. Method of Disposition crematory or other place) Department of F 1 Burial 2 X Cremation 3 Removal from State Pages Frederick, Maryland 10/19/2010 Stauffer Crematory 4 Donation 5 Other Specify. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Stauffer Funeral Home Frederick, MD 21702 Opossumtown Pike, 23a. Part I. Enter the disease, or complications failure. List only one cause on each line. Approximate Interval ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart sease, or complications tha **Physician** Retween Onset and /Me diest Death a. Contact Gunshot Wound of Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Couse (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical the attending physician and for use as the burial -UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b Was decedent pregnant in the Day Year 1 Live birth 3 Ectopic pregnancy Fetal death 2 past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown 9 Unknown this certificate has been signed by the director, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an autopsy prior to completion of cause of this certificate has performed? death? 2 No Yes Yes 2 ✔ No 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi completely filled in by the funeral director, 25. Was case referred to medical Be examiner? Other Nursing Home 5 Residence 6 Other Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ✓ Yes No 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death Certification: Subject shot self Oct 14, 2010 0000 hrs 1 Natural Yes 2 🗸 No Pending 2 Accident Investigation 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 🗸 Suicide Could not be or Town, State) 4411 Gene Hemp Road, Jefferson, MD determined (Specify) Yard Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d, Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifie October 14, 2010 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Russell Alexander MD Assistant Medical Examiner 32. Registrar's Signature 31. Date filed (Month. Day, Year State OCME ENLEGAND Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2335P Johnson nead rbara Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HICOMIC SALISBUTG REGIONAL NedICAL TENINSULA If Under 24 Hrs Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🕱 F Months Davs Hours (Month, Day, Year Country) 218-40-6214 6 Director maryland Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 X No Somerse Westover Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral S.A 21871 27839 Moore Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No and Mental Hygiene.
is marked other than "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: Black Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) Çollege (1-4 or 5+) Post -tev mail 12th grade WEUV Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ဂ္ Johnson Helen Handy Wintred 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rd Snead 7839 Jim Moore Westoven md 21871 - husband Ohte 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Upper-Hill, Ind. tamily Cemeter 10/23/10 Anthony E. Ward F. H. 22. Name and Address of Facility 21, Signature of Funeral Service Licensee 30639 Hampden Princess Anne M. 21853 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death signed by the a d be detached for Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? Yes 2 No has 1 Yes 2 No this certificate 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Division of Vital funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 5 Pending iniury work? 1 ☐ Yes 2 ☐ No 1 Natural To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completed filled in by the fur Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 10/14/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

100 E. CA(1011

OCT 19 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ALICE SHORES October 18, 2010 MARY 2:30 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Somerset Crisfield Alice Byrd Tawes Nursing Home | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 11/06/1928 5. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF 227-20-3847 Virginia 81 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10h. County 'natural", or items 23a or 28a-f show dical Examiner must be notified at 1 XYes 2 No Director Virginia Accomack Tangier Island 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23440 4419 Twin John Lane by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black. White, etc. 1 □ Never Married 2 □ Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🗓 No Specify: 3 N Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Accomack County Schools Teachers Aid ith and Mental Hygiel 27 is marked other the r traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be . Pages 1 and 2 should be filment of Health and Mental Hant: If Item 27 is marked ott George Edward Parks Lola Landon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 69 - Tangier, Virginia 23440 Rudy Shores (Son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or New Testament Church Cem. 10/21/2010 Tangier, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Solve of Fureral Solve Livensee

Mary Betty Bradsh 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St.-Crisfield, M 21817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed burial-tran and Due to (or as a consequence of) Box 68760. physician Physician/Medical th, as attending IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day for 4□Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown 9 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying, equise given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ð 22 No 1 Tyes 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has bage 2 s autopsy performed? Yes 2. No certificate 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA this funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day,

unde

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Day 2010 Physician/ MARGARET SMITH 1:14 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Doctors Community Hospital Lanham If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Months Days Hours Min Aug. 8, 1921 New York, NY Director 119-14-1511 Usual Residence of Decedent 28a-f shov 10b County 10c. City, Town or Location 10d. Inside City Limits with the Maryland the Medical Examiner must be notified at Director Maryland Prince George's Greenbelt 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural", or items 23a or Funeral 7804 Hanover Parkway, #102 20770 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black White, etc. þ 1 Never Married 2 Married permit. Page 1 and 2 should be filled within 72 hours after Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural", or 1 ☐ Yes 2X No Specify: Spec African American If Yes, Give Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Licensed Practical Nurse Healthcare Be injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Anna Louise Kitchener Albert Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13226 Musicmaster Drive Silver Spring, Maryland20904 Sandra Henry -daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date George Washington Cem. 10/12/2010 Adelphi, Maryland 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice Dőnald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 Worsed 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Salary Death Physician/ disease or condition Medical resulting in death) Examiner Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 Yes 2 No signed by the atte Day Month Year 1 Yes 2 D 9 Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. His in the conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> 1 Yes 2 No 3 Probably 4 Unknown Completed Hypertensive cardiomy opathy 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No Yes 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) <u>ام</u> Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 🗌 Yes 2 🗌 No 2 Accident 3 Suicide 4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D Completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check

State Registrar 29b. Signature and

title of certifier

30. Name and address of rson who completed cause of death (Item 23a) (Type, Print)

M. Schissler, MD.

Sertifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

,7500 Greenway Center Drive, Suito 430, Greenbelt, mo. 20110

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep		Mental Hygie		21 ((5
			Registrar	ertificate of Death	T	No 2010	34665
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death
	Medic		Jean R. Sansonett	1	October 1	11, 2010	8:00 P.M
	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Death	
- 45			Wilson Health Care Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Gaithersburg If Under 1 Year I If Under 24 Hrs.	O Date of Birth	Montgom	
	Funeral Director		721–18–2362 1 M 2 X F 95 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Jan 11.	1915 9. Birth	place (State or Foreign place) PA •
W.			Usual Residence of Decedent		Jan. II,	1717	IA.
	sho	tor	10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Mary 28a-1 otifie	irec	Maryland Montgomery Gaithe	rsburg			1 Yes 2 X No
	a or	al D	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Coul	ntry?
	h wit	Funeral Director	16444 Tomahawk Drive	20878		United Sta	ates
	deat riten iner		Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	e filed within 72 hours after death with the Maryland that Hygiene. And Hygiene. And other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	1 Never Married 2 X Married 1 Yes 2 No If Yes, Give Var or Dates	1 ☐ Yes 2 🛣 No Specify:		Specify:	
ŏ	atura cal E	Completed	Total of Dates.	edent's Usual Occupation	16	b. Kind of Business In	
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5	withir giene er th		4 Conege (1-4 of 54)	Librarian	Fi	nancial L	ibrary
ō	filed al Hy d oth) Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Maid	len Surname)	
<u>X</u>	ld be Ment arke	욘	Curtis O. Goodling		Mae S1	yder	
a	should be filed von and Mental Hyg is marked othe raumatic event,			ing Address (Street and Number or Rura			· ·
∠	and 2 lealth im 27 her to			Tomahawk Drive,			
0	ge 1 g it of H if ite or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☒ Removal from State 20b. Place of Disposition	matory or other place)	ľ	c. Location - City or To	own, State
Baltimore,	t. Pag rtmen rtant:				6/2010	York, PA	•
Ba	permit. Page 1 and 2 should be f Department of Heatth and Menta Important: If item 27 is marked any injury or other traumatic e	_		2. Name and Address of Facility DeV D East Deer Park D			D. 20877
			23a. Part 1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.				Approximate
-	hysician/		Immediate Cause (Final disease or condition Alzheimers Demen	tia			Interval Between Onset and Death Years
	Medical Examiner		resulting in death) Due to (or as a consequence of):				1,0010
		<u>.</u>	Sequentially list conditions, b.	1			
	0 ± L	nin	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying				
	and -trans	Examiner	Cause (Disease or injury that initiated events c. Due to (or as a consequence of):		_	-	
	death certificate be executed the attending physician and ed for use as the burial-transit	dical					
760	를 돌을 I	ledi	_ d				
687	eath certifica attending ph for use as th		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delive	erv
Вох	eath e atte	icia		Ectopic pregnancy Other (specify)		Month	Day Year
	r requires that the de been signed by the should be detached	پُر	9 ☐ Unknown 9 ☐ Unknown				
P.0	The law requires that the sate has been signed by the page 2 should be detach	β	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the	ne cause of death?
g Q	quire en si	Completed by	Osteoporosis		1 🗆 Yes	2 k No 3 □ Proi	bably 4 🗆 Unknown
Ö	aw re as be 2 sh	ed			24a. Was an autopsy	24b. Were auto prior to co	psy findings available mpletion of cause of
He He	The cate h	9			performed 1 ☐ Yes 2X		2 🗆 No
ta	s certificate has t lirector, page 2 s	m	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Check	(only one)		
5 ∣	Physical this call directions	은	1 Inpatient 2 ER/Outpatie			e 6 Other (Specify)
0	l or Attending Physician: after death. Director: After this certifical in by the funeral director,	Certificate:	1 X Natural 5 ☐ Pending (Month, Day, Year) injury	work?	28d. Describe how in	njury occurred	
SIO	deat deat ctor: y the	≝	2 Accident Investigation 3 Suicide 6 Could not be 4 Deposited determined 28e. Place of Injury - At home, farm, st		20f Location /Street	and Number or Rural	Pouto Number
Division of Vital Records,	after after Direction by		4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	root, ractory, office	City or Town, St		House Number,
_	to the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification properties of the funeral director; completed filled in by the funeral director;	edical	29a. Certifying Physician: To the best of my knowledge, death	occured at the time, date and place, and	d due to the cause(s) and manner as state	d.
	the H nin 24 the Ft nplete	Σ	(Check only one) 2 U Medical Examíner: On the basis of examination and/or inve	stigation, in my opinion, death occurred at death occurred at the time, date and plac	tne time, date and pl e, and due to the cau	ace, and due to the car se(s) and manner as st	use(s) and manner stated. ated.
			29b) Signature and title of certifier	29c. License number	29d.	Date signed (Month, I	Day, Year)
	IS		July 12 // Welivery M	D 19294	0	ctober 12,	2010
			30. Name and address of person who completed cause of death (Item 23a) (Type,	·			
	Stat		John R. Melnick, M.D., 911 Russell A 31 Date filed (Month, Day, Year) 32 Registrar's Signaper	venue, Gaithersbur	g, Maryla	nd 208/9	
	Stat Registra	_	31. Date filed (Month, Day, Year) OCT 1 4 2010 32. Registrar's Signature	Contract .			
				*			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Rose Elizabeth Spadacino 2010 <u>11:</u>52P [™] October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Greater Baltimore Medical Towson Cent If Under 24 Hrs Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country D.C. 1 □ M 2 🏻 F Months Days Dec. 8, 1924 579-26-9309 **Director** Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State Director 1 Yes 2 No Frederick Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 8485 Devon Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married þ Yes 21 No 21215-0036 Specify: White 1 Yes 25 No Specify If Yes, Give 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 18b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 72 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Salesperson Retail Be Maryland 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) 2 Paul Spadacino Carrie Fortunata Cilento permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. once. injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) George Spadacino/Brother Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
 8485 Devon Lane, Walkersville, MD 21793 Baltimoré, 20a. Method of Disposition 20b. Place of Disposition (Name of œt. 2010 20c, Location - City or Town, State cemetery, crematory or other place)
Gate of Heaven Cemetery 1 K Burial 2 Cremation 3 Removal from State Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses ²² Name and Address of Fasility Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ days Pneumonia Tue to (or as a consequence of): disease or condition Medical resulting in death) Examiner metastatic Vulvular cancer veas Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or ilinjury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🛣 No
9 ☐ Unknown Year Day Pregnant Unknown Month Pregnant at time of death the be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page 2 certificate 25. Was case referred to medica B 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 X No မှ 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director; After this 28a. Date of injury (Month, Day, Year) funeral Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural | Natural | Accident | Suic 5 Pending injury Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined To the Hospital Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certi 29c. License number 29d. Date signed (Month. Day, Year) OW October 16.2010 D047223 10

Registrar

State

St.

Karen M. Lynn Piper, MD

5218

Baltimore

71204

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month OCT. 2010 8:43 PM LEONARD SMALL Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner KENSINGTON PARK-WOODLANDS MONTGOMERY KENSINGTON 5. Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, MARCH 3 NEW YORK 1 X M 2 □ F Months Hours Min Director 1925 081-18-5223 85 Usual Residence of Decedent 28a-f show 10a. State 10h. County 10d. Inside City Limits 10c, City, Town or Location notified at Director 1 Yes 2 □ No MD. MONTGOMERY KENSINGTON 10e Street and Number 10f. Zip Code 0 10g. Citizen of What Country? the Medical Examiner must be Funeral 23a 3618 LITTLEDALE RD. 20895 U.S.A. items hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14 Bace - American Indian. Armed Forces?

1 X Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ģ 1 Never Married 2 Married 1 X Yes If Yes, Give "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: 3 X Widowed 4 ☐ Divorced WWII WHITE Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) GOV'T. 5+ SCHOOL PSYCHOLOGIST MONTGOMERY CO. permit. Page 1 and 2 should be filed wir Department of Health and Mental Hygie Important: If item 27 is marked other: any injury or other traumatic aucan ** Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) မ **GEORGE** SMALL SADIE SHWARTZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LAURA S. HALL/DAUGHTER NELSON ST., ROCKVILLE, MD. 20850 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗆 Burial 2 🌠 Cremation 3 🗆 Removal from State 10-19-2010 RIVERDALE, MD. 4 Donation 5 Other (Specify) CHAMBERS CREMATORY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A.
5801 CLEVELAND AVE., RIVERDALE, MD. 20737 Tham. reix 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 4 YRS. shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ a RENAL CELL CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): requires that the death certificate be executed Cause (Disease or iinjury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No ρ Month Day Year Other (specify) Pregnant at time of death signed by the a g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Hospital or Attending Physician: The law page 2 autopsy certificate 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Division of Vital funeral director, 26. Place of Death (Check only one) Be Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specif Hospital: 잍 1 Inpatient 2 ER/Outpatient 3 I DOA this 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred After injury e Hospital C. n. 24 hours after death.

he Funeral Director: Aff 1 X Natural 5 Pending Accident
Suicide Investigation 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registr<u>ar</u> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Registrar's Signatu

BRENT

31. Date filed (N

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COLE,

D0060129

10215 FERNWOOD RD., SUITE 100, BETHESDA, MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) October Physician/ 14, 2010 07:50 A M Audrey Mae Spann Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Southern Maryland Hospital Clinton 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days April Day, Months 1 □ M 2 🔀 F Virgi<u>nia</u> 85 **Director** 228-22-8723 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State Director 1 X Yes 2 No Seat Pleasant Prince George's Maryland| 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral United States 6706 Seat Pleasant Drive 20743 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married ò 1 ☐ Yes 2 No Specify. African American nan "natural", If Yes, Give Year or Dates Specify: 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Government 12th Accounting Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, ္ပ Marice Mosly Sam Gatewood traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 20743 6706 Seat Pleasant Drive Seat Pleasant, Md. Renee Spann-Graham - Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition October 21, 1 A Burial 2 Cremation 3 Removal from State Landover, Maryland Harmony 4. ☐ Donation 5 ☐ Other (Specify) 2010 atore of Funeral Service Lige 22. Name and Address of Facility Stewart Funeral Home, Washington, DC 4001 Benning Road NE 23a. Part 1 Ent 1 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock. In art failure. List only one cause on each line.

Immediate Cause (Final disease or condition in death)

a.

A three final fin Approximate Interval Between Onset and Death with Respiratory Failure Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence oi). attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Day ate has been signed by the atte page 2 should be detached for Month Year Pregnant at time of death Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes 2 🖪 No Yes within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred lospital or Attending Pl 4 hours after death. uneral Director: After th 27. Manna of Death injury 1 Natural 5 Pending Accident Suicide Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29b. Signature and title of D005 5120 Uctober 14 2010 m) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1329 Southern avenue SE Suite 310 Washington DG 20032 Richard Palmer mo 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

OCT 2 0 2010

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar per PHY PGH 10 Postificate of Death Amend #23a 2. Date of Death 1. Decedent's Name (First, Middle, Last, Month / O ABORN Physician/ 2220 M RNESTINE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel <u> Annapolis</u> Anne Arundel Medical Center 8. Date of Birth (Month, Day, Year) 09/08/1913 . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number Funeral Country)
New York, N. Y Days Min. 1 □ M 2 🗹 Months Hours 97 Yrs. 064-01-7418 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director 1

Yes 2 □ No Baltimore Hunt Valley Md 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 21030 U.S.A <u> 11711 Hunters Run Drive</u> Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces' Black White etc. þ 1 Never Married 2 Married Yes 2 XNo African-1 ☐ Yes 💥 ☐ No Specify: If Yes, Give Completed 3 Widowed 4 Divorced <u>American</u> Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Education Teacher-Director of Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Anna Bell Canady Edward Greenleaf Seaborn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21030 11711 Hunters Run Dr., Hunt Valley, Md. Anita E. Richmond-Ross/Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 10/25/10 The Woodlawn Cem. Bronx, N.Y. 4 ☐ Donation 5 ☑ Other (Specify) Entombment 22. Name and Address of Facility
Henry S. Washington & Sons Co., Inc. 21. Signature of Funeral Service Licenses ans Burroughs Ave., N.E., Washington, D. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Immediate Cause (Final Physician/ ES cu disease or condition Medical resulting in death) Due to (or as a Ansequence of) **Examiner** spiration pneumonia Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) Unknown been signed by the sahould be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? has performed? 1 🗌 Yes 2 🗆 No 1 Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Be examiner? 2/ No Hospital: Other: 1 🗌 Yes Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) ဂ within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: work? 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certific 29c. License number ame and address of person who completed cause of of death (Item 23a) (Type Print) Date filed (Month, Day, Year) 32. Registrar's Signature State 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		101	partment of Health and Netrificate of Death	Mental Hygie Reg.	2010	34670		
Physici	an/	1. Decedent's Name (First, Middle, Last)		2. Date of Death	Day 4 - Vaar	3. Time of Death		
Med Exami	ical	Aa. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	10	4c. County of Death	0700AM		
		Anne Anndel Medical Center	Annapolis,	MD	Anne An			
Funera Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 1 1 M 2 1x F 97 Yrs	Months Days Hours Min	8. Date of Birth	9. Birthpla Country	ce (State or Foreign MD		
nd how at	٦ ام	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		100	d. Inside City Limits		
Maryla 28a-f s atified	Director	MD Prince Georges Foresty	rille			1 🗌 Yes 2 🄼 No		
ith the 3a or	ra D	7805 Kipling Parkway	10f. Zip Code 20747		. Citizen of What Country	•		
leath w Items 2	Funeral		Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	Inited State 14. Race - American	Indian,		
after d al", or i	d by	1 Never Married 2 Married 1 Yes, Give 3 X Widowed 4 Divorced Year or Dates.	1 ☐ Yes 2 🕱 No Specify:	riidari, etc.)	Black, White, etc			
Z15-UU36 in 72 hours after e. nan "natural", o Medical Exam	Completed	15. Decedent's Education 16a. De	cedent's Usual Occupation we kind of work done during most of work	ina 16t	b. Kind of Business Indus			
7121 /ithin 7/ iene. r than	Com	Elementary/Seconday (0-12) College (1-4 or 5+)	. DO NOT use retired) Ltress	·	estaurant			
Baltimore, Imaryland 21213-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highy or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (First, Middle, Last) George Schumacher		ne (First, Middle, Maid	den Surname)			
Maryland 2 should be filed th and Mental Hy 27 is marked out traumatic even	-		ailing Address (Street and Number or Rur.					
nd 2 sh nd 2 sh ealth a m 27 is ner trau		Rita Gardner / Daughter 7805	Kipling Parkway,	Forestvill	le, MD 20747	7		
Saltimore, permit. Page 1 and Department of Hea mportant: If item any injury or othe once.		1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, c	rematory or other place)		c.Location - City or Town orestville,			
altir rmit. Pa spartme spartme sportan sy injur		4 ☐ Donation 5 ☐ Other (Specify) Epiphany 21. Signature of Funeral Service Licensee	22. Name and Address of Facility Le					
n sares		Cary J: coff 23a(Part 1. Enter the disease, or complications that caused the death. Do not	8125 Southern Mary		, ,	MD 20736 Approximate		
Physician		shock, or heart failure. List only one cause on each line.		or respiratory arrest,	ŀr	nterval Between Onset and Death		
Medica Examine	1	resulting in death) a. Due to (or as a consequence of):	101032			39/3		
		Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):						
cuted and transit	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of):						
foU sate be executed physician and the burial-transit	dical E	resulting in death) Last Due to (or as a consequence of):						
os four certificate b rding physicse as the b		IF FEMALE:						
DIVISION Of VITAI RECORDS, F.O. BOX 68/60 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transic.	Physician/M		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Da	ay Year		
that the denoted by the edetached	Phys	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the	ee underlying cause given in Part I	220 Did tohoo	co use contribute to the	anuna of doath?		
S, F, rires that is signed id be de	Completed by	1	e underlying cause given in Farci.		2 No 3 Probal			
Sord aw requas beer 2 shoul	plete	Aortic Stenosis Congestive heart fuiture		24a. Was an autopsy		y findings available pletion of cause of		
He(performed		⊠ No		
VITAI ysiciar is certif directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpa	26. Place of Death (Checularitient 3 DOA Other: 4 Nursing Ho		e 6 Other (Specify)	4		
DIVISION OT VITAI HECOTAS, tat or Attending Physician: The law requires is after death. al Director: After this certificate has been signed in by the funeral director, page 2 should be		27. Manner of Death 1 № Natural 5 □ Pending 28a. Date of injury (Month, Day, Year) injur	y work?	28d. Describe how in	njury occurred			
Attencer deatlecter: ector: by the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)			t and Number or Rural Re	oute Number,		
DIV oital or ours aftu eral Dir filled in			P.	City or Town, Si				
ne Hosp n 24 ho ne Fune pleted 1	Medical	29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, deal of the control of the basis of examination and/or in a certifying Nurse Practioner: To the best of my knowledge of the control of the certifying Nurse Practioner: To the best of my knowledge of the certifying Nurse Practioner: To the best of my knowledge of the certifying Nurse Practioner: To the best of my knowledge, deal of the certifying Nurse Practioner: To the best of my knowledge, deal of the certifying Nurse Practioner: To the best of my knowledge, deal of the certifying Nurse Practioner: To the best of my knowledge, deal of the certifying Nurse Practioner: To the best of my knowledge, deal of the certifying Nurse Practioner: To the best of my knowledge, deal of the certifying Nurse Practioner: To the best of my knowledge, deal of the certifying Nurse Practioner: To the best of my knowledge of the certifying Nurse Practioner: To the best of my knowledge of the certifying Nurse Practioner: To the best of my knowledge of the certifying Nurse Practioner: To the best of my knowledge of the certifying Nurse Practioner: To the best of my knowledge of the certifying Nurse Practioner: To the best of my knowledge of the certifier of th	vestigation, in my opinion, death occurred a	t the time, date and p	face, and due to the cause	e(s) and manner stated.		
To the virthing complete the co		29b. Signature and title of certifier Authority (MD)	29c. License number		Date signed (Month, Da	y, Year)		
		30. Name and address of person who completed cause of death (Item 23a) (Typ	D69 56 6		10/17/10			
den 3		Ivelisse Michel MD 2001 Med 31. Date filed (Month, Day, Year) 32. Registray Signature	9. Souls	Annapoli-	s,MD ZI	401		
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	Physicia Medic		Edward Eugen	e Stivers							October	18,	2010 Year	8:09 A™
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ئمہ		4	1084 Cattle Dri		o (In um la	ast birthday)		sby r1 Year	If Under	24 Ure	O Data of Birt		alvert	
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	and show lat	or	10a. State 10b. County		10c. City	y, Town or Lo	ocation						10d. Inside City Limits	
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	r iten iner		11. Marital Status 1 ☑ Never Married 2 ☐ Marr	12. Was Decedent Armed Forces?		S. 13. V	13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica					14.	Race - Ame Black, Whit	erican Indian, e, etc.
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Σa	2 sho th an 27 is trau		Susan M. Wommac		·			Address (Street and Number or Rural Route Number, City or Town, State, Zip Coo ${ t Cattle}$ Drive Ln., Lusby, Maryland 206 ${ t S}$						
ē,	f Heal f Heal item other		20a. Method of Disposition	ok / Dibect	20b. P	lace of Dispo	sition (Na	ne of			Date			Town, State
D U	Page 1 nent of ant: If it ury or o		1 ⅓ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		, I	emetery, cren ar Hill	-			10/2	3/2010	Suit	land	Maryland
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service L		, (usch Fu			
Ö	Pe I I I	1	Thickard Ker	un Hard	ever,) F	.0.	Box 6	500,	Lusb	y, Mary	land_	20657	
			23a. Part 1. Enter the disease, or shock, or heart failure. List o	complications that cause	d the deat	Do not ente	er the mod	le of dying	g, such as	cardiac o	or respiratory arr	est,		Approximate nterval Between
Ŧ	ำเงูรเ่ต่อแก	3 19	Immediate Cause (Final disease or condition	i Je	15/5						/	i j	1	Onset and Death
	Medical Examiner		resulting in death)	Due to (o) as	a consequ	ience		/	/		1		-	
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	ted nsit	Examiner	Cause (Disease or linjury	OUADRI		-				1	/ / PORONA	DIVED BY MEDICAL EXAMINE		
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87	rtifica ing ph e as tl	Physician/Medica	IF FEMALE:	00. 1/										
Box 68760	eath certifica attending p	ian,	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Feta	al death 3 🛚	Ectopic Other (s		у			230	d. Date of de Month	livery Day Year
ă.	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant : 9 ☐ Unknown	at time of c	ieam 5∟	ı Otner (s	oecny)	-					
P.O.	es that the des signed by the a be detached t	by Pł	Part II. Other significant condition	ons contributing to death	out not res	ulting in the u	nderlying	cause giv	en in Part	I.	23e. Did to	bacco use	contribute to	the cause of death?
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Rec	Physician: The law this certificate has ral director, page 2.3	com									perfo	rmed?	death?	s 2 🗆 No
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פר	ding F th. After 1 funera	ate:	27. Mann f Death Z Natur 5 ☐ Pendin	28a. Date of inj (Month, Da	y, Year)	28b. Time of injury		28c. Injury work Wark	rat ? Yes 2.□	, ļ	A Pesoribe h	^{pw} Ś TR U	CKed A I	DIVIDER AND
Sio	ttenc death stor: /	Certificate:	2 X Accident Investig 3 ☐ Suicide 6 ☐ Could	not be 28e Place of In		2:15 A			Yes 2L	-	OVERTURN	Aug a4 a a ad A1	umber or Bu	ıral Route Number,
Division of Vital Records,	II or Attend after death Director: // d in by the f		4 Homicide determ	building, et ROADWA	c. (Specify)	set, lactor	y, onice			City or Tow PORT HU	n, State) H	ÜENEMI	E & NAVAL AI
	ospita hours uneral	ledical		Physician: To the best o	f my knowl						nd due to the ca	use(s) and n	nanner as sta	ated.
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. Within 24 hours after deather this certificate has been signed by the attending physici To the Purneral Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Me	only one) 3 Certifying	Nurse Practioner: To the			death occu	rred at the	e time, dat		ce, and due to the	e cause(s) ar	nd manner as	
_	5 vit		29b. Signature and title of certifier	he was			29	c. License	number	ンフ		29d. Date s	igned (Mont	n, Day, Year)
			30. Name and address of person v	19,101)	dooth //	. 02a) #t = =		10	///) 5		1010	DET.	18,2010
RV	1 (Su. Name and address of person V	Who completed cause of a	Solution	a liype, H		010	001	Th.	Sorial.	MA	20	178
	Stat	e.	31. Date filed (Month, Day, Year)	32. Regist	aris Signal	ture	X) (/	O TAIN		1-189	WHIII)	TRUI)		1-0
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October Scallion. 20 Î 1918 Nicholas John PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington 1612 Woodlands Run Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) Funeral 1 M 2 - F Yrs Director 207-22-7723 linois Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Washington Hagerstown 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? U.S.A. 1026 The Terrace 21742 12. Was Decedent Ever in U.S.
Armed Forces?
1 ■ Yes 2 ■ No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify. Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of the control of the contr during most of working and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental H Important: If item 27 is marked any injury or at ည Leonard Scallion Marv Walko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ellen Scallion / 1026 The Terrace Hagerstown Maryland 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/22/2010 Hagerstown Maryland Rest Haven Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel |1601 Pennsylvania Ave. Hagerstown Maryland 21742 23a. Part 1. Enter the disease, or complication hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one car Parcreche Immediate Cause (Final Physician/ disease or condition resulting in death) monto Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) and I-transit Exami Cause (Disease or lintury that initiated events resulting in death) Last Due to (or as a consequence of) burialphysician the buria Physician/Medical that the death certificate be attending p IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death ed by the a g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician; The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has performed? Yes 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 🗌 Yes ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 DO Other (Septe)s Residence this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending ours after death.

neral Director: Af
I filled in by the fu 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

ASH 11H

To the

within 2

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 32. Registrar's Signature OCT

Morneck

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practiceer: To the best of my knowledge, death occurred at the time, date and place, and due to the car

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ <u>Patricia</u> ODE Marie Staubs Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 XF Months Days Hours Min Maryland Director 215-34-3822 Yrs. o3//23/1939 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 28a-f Yes 2 No Maryland Washington Hagerstown 10e Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 55 East Washington St. 21740 U.S.A. hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates. "natural", 1 🗌 Yes 2 🕽 No Specify 3 Widowed 4 Divorced Specify: Completed White the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 }
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, the Media 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 Elementary/Seconday (0-12) College (1-4 or 5+) 8 <u>Enviromental</u> <u>Services</u> Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Joseph Samue1 Lizor Minnie Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diana Washington / Daughter 7104 B Short Dr. Williamsport, Maryland 21795 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 10/21/2010 Hagerstown Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Rest Haven Funeral Chapel 5-Ma 1601 Pennsylvania Ave. Hagerstown Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Se wentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day 2 No Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Hinknown 24a. Was an 24b. Were autopsy findings available after death.

Director: After this certificate has the control of autopsy prior to completion of cause of death? performed? 1 Yes Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 ☑ No Other: ၉ 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 1 Natural
2 Accident 28d. Describe how injury occurred 5 🗆 Pending 1 Yes 2 No Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) cause of death-(Item 23a) (Type, Print) and address of person who completed 13H-2 11110 medical واعملكا 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1-State of Maryland / State of Maryland / Personal State of Maryland / Per	Department of He r dr/fh, g910 Certificate of De	alth and Mental Hygi 12/03/2010dhb eath Re	ene g. No.2010 34674
	Physicia	n/	Decedent's Name (First, Middle, Last)	<i>-</i>	2. Date of Death Month	3. Time of Death
	Medic	al	1 Jexter	4b. City, Town, or Lo	iO	16 2010 /: 36 4 M
	Examin	er	4a. Facility Name (if not institution, give street and number) Prince George's	1	Cheverly	Prince Garge
	Funeral	-	5. Social Security Number 6. Sex 7, Age (In yrs. last bin	thday) If Under 1 Year Months Days	f Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day,	9. Birthplace (State or Foreign (ear) Country),
	Director		Usual Residence of Decedent	Yrs.	7-27-	1957 Mangland
	show dat	tor	10a. State 10b. County 10c. City, Tow			10d. Inside City Limits
	Mary 28a-1 notifie	Jirec	Margland Charles Walc	10f. Zip Code		1 ☐ Yes 2 ☐ No
	/ith th	ral	10e. Street and Number 6001 2001 Syzanze Rd	2060		U.S.A
	leath v items er mu	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hisp	anic Origin? (Specify Yes or No- Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	after d	d by	1 Never Married 2 Married 1 Never Married 1 No If Yes, Give	1 ☐ Yes 2 ☑ No		Specify: Blade
9	hours natura lical E	Completed	15. Decedent's Education 16a	. Decedent's Usual Occupati	on	16b. Kind of Business Industry
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9	ed with Hygien Sther i	மெ	17. Father's Name (First, Middle, Last)	• 10	8. Mother's Name (First, Middle, Mi	aiden Surname)
lan	d be fill dental irked o	욘	James E SAVOY		Irene	Chasley
lan	should and N is ma rauma		19a. Informant's Name/Relationship (Type, Print)		Number or Rural Route Number, 0	City or Town, State, Zip Code)
e,	and 2 Health tem 27			of Disposition (Name of	100	206 - City or Town, State
altimore, Maryland 21215-0036	Page 1 nent of ant; If i		1 Burial 2 Cremation 3 Removal from State	ery, crematory or other place)	10-23-10	Walduf MD
Balti	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signatur o Funeral Service Licensee	22. Name and Address		Aguara Mi) 20608
			23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.		such as cardiac or respiratory arres	Interval Between
- 3	nysician/	ř i	Immediate Cause (Final disease or condition			Onset and Death
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		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			
	cuted ind transit	Examiner	Cause (Disease or iinjury that initiated events			
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3760	ificate ig phys as the	Medi	IF FEMALE:			
Box 687	eath certifica attending pl	Physician/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1	th 3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
B	ne dea y the a	hysic	1 Yes 2 No 9 Unknown 9 Unknown	5 🗆 Other (specify)		
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eco	e law n s has b ge 2 st	jd m			24a. Was an autops perform	y prior to completion of cause of death?
E B	sician: The law i s certificate has t lirector, page 2 s	Be Co	25. Was case referred to medical	26. Plac	1 ☐ Yes 2 e of Death (Check only one)	PIONO 1 Yes 2 M NO
Yit	hysici his cer il direc	유	examiner? 1 ☐ Yes 2 🕅 No Hospital: 1 ☐ Inpatient 2 🛍 ER/C		4 Nursing Home 5 Reside	
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Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director.	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, f			eet and Number or Rural Route Number, State)
Ö	Hospital or 24 hours afte Funeral Dire	ical	29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge	, death occured at the time, o	late and place, and due to the caus	e(s) and manner as stated.
	To the Ho within 24 P To the Ful completed	Medical	(Check 2 Medical Examiner: On the basis of examination and only one) 3 Certifying Nurse Practioner: To the best of my known	vledge, death occurred at the t	ime, date and place, and due to the	cause(s) and manner as stated.
ø	Voit To 1		29b. Signature and title of certifier	29c. License r	21 21 21 21 21 21 21 21 21 21 21 21 21 2	9d. Date signed (Month, Day, Year)
	2 RLI		30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)	01. 1 140	20785
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	l de l'	Chevery VIII)	00703
	Registr	ar	OCT 2 0 2010 Leneus B	. parke		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 | 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William Smith James Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death WMHS-RMC Cumberland Allegany 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) MD If Under 24 Hrs. 8 Date of Birth **Funeral** Min 1 M 2 D F May 27 1940 215-36-9291 70 Director Usual Residence of Decedent or 28a-f shov er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 □**X**es 2 □ No MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 16 East Elder Street USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
T Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: Completed 3 Widowed 4 Divorced white 1961-1965 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 !
Department of Health and Mental Hygiene.
Important: If item 27 is marked other trans "na any injury or other traumatic event". (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Police Officer Cumberland Police Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Thomas G. Smith Mary Elizabeth (House) Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela Smith Wife 16 East Elder MD 21502 Cumberland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 10/27/2010 Restlawn Memorial Gardens MD I a∀ale 21. Signature of Funeral Service Licenses 22. Nam Scarbelli Fufferal Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. ath. Do not enter the mode of dving, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or se a consequence of) If any, leading to immediate cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year 2 JUS 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ thinknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? ers after death.

eral Director: After this certificate I filled in by the funeral director, page 2 🗌 No 2 4 1 🗌 Yes Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 INO 1 Tyes 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate; 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 🛂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 25 10 006643 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12502 Willowbrook Rd. Suite 300 Cumberland MD <u>Blanche Mavromatis</u> 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

10-07971 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Larry Schnakenberg 1. For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) Larry Allen Schnakenberg, 2. Date of Death Physician/ Month Day October 17, 2010 Medical Examiner 0635 hrs 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Memorial Hospital Havre de Grace 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) **Funeral** Day Hours Country) Texas Director 37 05/07/1973 402-96-6062 1 X M Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 'n 1 X Yes 2 No 28a-f show Havre de Grace Harford Maryland more, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after death with the Maryland neut of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. notified at once. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21078 United States of America 716 Otsego Street Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Armed Forces? 1 X Yes If Yes, Give Year or Dates: 1 Yes 2 X No specify: Specify: White Divorced 1993 <u>۾</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Health Care Paramedic 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen Frances Owen Larry A. Schnakenberg, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ပ 716 Otsego Street, Havre de Grace, Maryland 21078 Baltimore, MD Heidi Schnakenberg (wife) 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 10-22-2010 Darlington, Maryland Rock Run Cemetery 4 Donation 5 Other Specify: 22 Name and Address of Facility Zellman Funeral Home, P.A. 210, 123 S. Washington St. Havre de Grace, Maryland ervice Licensee Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Retween Onset and failure. List only one cause on each lin Wednesd Mixed drug (oxycodone, tramadol,) and alcohol Death Immediate Cause (Final disease Examiner Due to (or as a consequence of): Intoxication or condition resulting in death) Sequentially list conditions If any, leading to immediat Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and tran Physician/Medical X UNPENDED attending physician or use as the burial AMENDED 23a,27,28a-f,per ME g909 11/30/10 TT certificate be Division of Vital Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy dent pregnant in the 2 Fetal death Live birth 3 Ectopic pregnancy Day Year Month past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown signed by the ar Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 🗸 Unknown Completed this certificate has been a director, page 2 should 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? page ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Hospital or Attending Physician: examiner? Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 Other: Nursing Home 5 Residence 6 Other: DOA 1 V Yes 2 No 28a. Date of Injury (Month, Day, Year) After 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work Natural unk Director: d in by the f Pendina 24 hours after death. Fd 10/17/10 Fd 0535 hr 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) / 16 Ostego St Havre De Grace, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be 3 Suicide determined residence Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the 1 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 17, 2010 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

31. Date filed (Month, Day, Year)

ORIGINAL

arks

32. Registrar's Signature

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 30 Physician/ TURAY 11:24PM AMIE Medical 2010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Georges Doctor's Community Hospital Prince Lanham If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🛣 F Months Days (Month, Day, Year Hours Country) Director 48 219-59-8859 1962 Sierra Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 No MD Prince Georges Lanham 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20706 USA 9801 Good Luck Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Specify: Black 1 ☐ Yes 2 🛣 No Specify. 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Ħealth Care Nurse years Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ <u>Haja Ramatu Jalloh</u> . Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark Alhajie Raffieu Jalloh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stanford Pl. Waldorf, MD 20602 <u>Abdulai Jalloh/Brother</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Maryland National Dct.3,'10 |Laurel, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Latney's Funeral Home 20011 M.a. Hussain 8831 Georgia Ave., NW Washington, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each rine. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year been signed by the sahould be detached 1 | Yes 2 L Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 a autopsy performed 2 🗆 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending e notes in 24 hours after uses... the Funeral Director: Aft work' 2 Accident
3 Suicide
4 Homicide 1 Tyes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2

To the F

complete 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cal annapolis Rd., Suite 210, Canham State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #26 Per Phy G909 II/15/10 JH
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 Year)AMES TOLER October 16, 18:27 РМ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Prince George's Hospital Center Prince George's Cheverly 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) Funeral 1 X M 2 □ F Months Days Min Hours Yrs Director 233-24-8395 Jan. 88 Usual Residence of Decedent 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No DC Washington ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20019 United States 48-53rd Place SE items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 0 þ 1 Never Married 2 X Married 1 Yes 2 X No Specify. Specify: Black "natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Accountant Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic. other traumatic Robert Toler Lennie (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorraine Lucas-Toler / Wife 48-53rd Place SE Washington, DC 20b. Place of Disposition (Name of cemetery, crematory or other place)
Quantico
National Cemetery 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State October 25, 4 Donation 5 Other (Specify) Triangle, Virginia 21. Signature of Funeral Service Lig 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease Coronaly artery disease or condition resulting in death) , Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed fours after death.

24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death Day Year 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 W 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 욘 7X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Hesidence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural injury work? 5 Pending Accident 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the l within 2 To the l 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HUSSAIN

32. Regi

WASTEM

00054272

Goodback Rd Suite 300 Lanham Md 201016

10-18-10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 12.35 PM Iramia 101/101 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hagerstown Washington Village Ravenwood Lutheran If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 1 □ M 2 🗓 F 261-02-6745 88 Director Jan. 16,1922 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Funeral Director Maryland Washington County Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1183 Luther Drive 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2√CXNo Be Completed by Specify Specify: White 3 ☐Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Personal Residence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Russell Alfred Hartley ဥ Gertrude Virginia Turner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marianne Hawbaker / Niece 325 Pangborn Blvd., Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Rose Hill Cemetery Oct. 25, 2010 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. N. Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Conom 4 arten MINO /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ♣ No 24a. Was an autopsy performed? Yes 2 X No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 29a. Certifier Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D28365 30. Name and address of person who complete (cause of death) tem 23a) (Type, Print) Street Hagetim MD AN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/200

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	4	For State Registrar	Otate of Wi	ai yiaii	-	tificate of L		ivionital Hy	Reg. No.	2010	34680
Physicia Medic		1. Decedent's Name (First, Middle, L Anne Marie Veihme		-				2. Date of De Month October		2010 Year	3. Time of Death 11:30 p M
Examin		4a. Facility Name (if not institution, gi 3330 N. Leisure Wor		06		4b. City, Town, or Silver	Location of Death	1	4c. County of Death Montgomery		
Funeral Director		5. Social Security Number 6. 578–14–1755			st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month Da June 16	rth ay, 1914	9. Birthp Count	lace (State or Foreign ry) DC
Maryland 28a-f show otified at	Funeral Director	Usual Residence of Decedent 10a. State 10b. County MD	Montgomery	10c. City	, Town or Lo	cation ver Spring				1	0d. Inside City Limits 1 ☐ Yes 2 🖰 No
with the 23a or 1 ust be no	eral D	10e. Street and Number 3330 N. Leisure Wor	ld Blvd., Apt	. 1006	5	10f. Zip Code 20906			10g. Citiz USA	en of What Coun A	try?
, r'ë	침	11. Marital Status 1	12. Was Decedent E Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.			Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🔀 No		oecify Yes or No o Rican, etc.)		4. Race - Americ Black, White, e pecify: White	tc.
Baltimore, Maryland 21215-0036 Jennit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. mportant: If item 27 is marked other than "natural", o ny injury or other traumatic event, the Medical Exam one.	Completed	15. Decedent's (Specify only highest Elementary/Seconday (0-12)		f) (Gi 1-4 or 5+) life		dent's Usual Occup kind of work done o O NOT use retired) nistrative	king	Law Firm		fustry	
land Z be filed w lental Hyg rked othe iic event,	To Be	17. Father's Name (First, Middle, Last Oliver T. Veilmeye					18. Mother's Nar	me (First, Middle arie Brad	,	urname)	
Marylanc d 2 should be file alth and Mental I 27 is marked o		19a. informant's Name/Relationship Catherine V. Hughes				ng Address (Street a our Oaks Lai				own, State, Zip C	ode)
imore, Page 1 and Tent of Heal ant: If item; ury or other		20a. Method of Disposition 1 Regurial 2 Cremation 3 4 Donation 5 Other (Spe		0	emetery, crer	sition (Name of matory or other place ret Cemeter		Oct. 16, 2010		ington, DO	
Baltimon permit. Page 1 Department of Important: If is any injury or of		21. Sign, ure of Funeral Service face	scerlo		22 Fi	Name and Addre rancis J. C O Universi	ss of Eacility Ollins Func ty Blvd. W	eral Home ., Silver	Inc. Spring	g, MD 2090	1
Physician		23a. Part 1. Enter the disease, o co shock, or heart failure. List only Immediate Cause (Final disease or condition	mplications that caused one cause on each line Congestiv		n. Do not ente	er the mode of dyin				11	Approximate Interval Between Onset and Death mon ths
Medical Examiner		resulting in death)	Due to (or as	Due to (or as a consequence of):							
uted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. First or this Cause (Disease or linjury that initiated events	Due to (or as								
8760 ifficate be exectly by the physician are as the burial-t	resulting in death) Last Due to (or as a consequence of): d.										
Box 68 death certi he attendin ed for use	Physician/Me	IF FEMALE; 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 X No 9 Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Feta	Ideath 3	Ectopic pregnand Other (specify)	ey .		23	3d. Date of delive	ery Day Year
S, P.O	Þ	Part II. Other significant conditions COPD, Atrial Fibril	· ·			underlying cause given	ven in Part I.				e cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by the din by the funeral director, page 2 should be detach	Completed							_ perf	s an opsy ormed? 2 🙀 No	24b. Were autop prior to con death? 1 \(\sum \) Yes	osy findings available impletion of cause of
ilan:	Be	25. Was case referred to medical examiner?					ace of Death (Che				
hysic this ce	၉	1 Yes 2 No				nt 3 🗆 DOA Oth	4 L Nursing F			Other (Specify))
ending Peath. Pr. After the funera	Certificate:	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigat 3 Suicide 6 Could no		ry y, Year)	28b. Time of injury	work		28d. Describe	how injury	occurred	
Divisi		4 Homicide determine	d 28e. Place of Inju	. (Specify)	eet, factory, office		City or To	wn, State)	Number or Rural	
the Hosp in 24 hou he Funer ipleted fil	Medical	(Check 2 Medical Exa	nysician: To the best of miner: On the basis of e urse Practioner: To the	xamination	and/or inves	tigation, in my opinio	on, death occurred	at the time, date	and place, a	and due to the cau	use(s) and manner stated.
Ole a with a		29b. Signature and title of certainer	X MS			29c. Licenso D 3	+740	(M&)		oct. 12, 2	
		30. Name and address of person wh Robert Fields, MD	completed cause of d				ney, MD 20	832			
Stat Registra		31. Date filed (Month, Day, Year)	37. Registra	ar's Signat	bar bar	Med.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State	of Maryla		artment of F		d Mental		ne 0	0	34681
			Decedent's Name (First, Middle	, Last)					2. Date	of Death	,		3. Time of Death
	Physici		HERMAN W. VOS	SHELL. J	R.				OCTO		Day 26, 201	Year	11:50p M
×	/Medic Examin		4a. Facility Name (If not institution				4b. City, Town, o	r Location of D			4c. County	~	
			329 Cypress St.				Milling	ton			Kent		
	Funeral		5. Social Security Number	6. Sex		rs. last birthday		If Under 24 I		of Birth	ear)	9. Birth	olace (State or Foreign
	Director		214-32-5266	1 2X M 2□F	75	Yrs.			July	h, Day, Y, 7 1 1	935	Maı	ryland
	and		Usual Residence of Decedent 10a, State 10b, County		10c.	City, Town or L	ocation						10d, Inside City Limits
	Maryl f sho	ō	MD Kent		М	illingt	on						1 Yes 2 No
	28a-	rect	10e. Street and Number		11		10f. Zip Code			10g	. Citizen of W	hat Cou	ntry?
	3a or	Funeral Director	329 Cypress St.				21651			r	J.S.A.		
	ms 2	era	11. Marital Status	12. Was De	cedent Ever in	n U.S. 13	Was Decedent of H	lispanic Origin	? (Specify Yes		14. Race		can Indian,
9	or ite	Ē	1 ☐ Never Married 25 Marr	ed 1 Tes	2 √No		1 ☐ Yes 2 ☑ No	Specify:	ueno Alcan, elc	;.)		k, White, זיי	eic. nite
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Everther must be incitied at	d by	3 Widowed 4 Divorced	Year or	Dates:		10165 2,20140	Specify.			Specify:		
<u>.</u>	"natu	Completed	15. Decedent (Specify only highes	's Education It grade completed	1)	16a. Deci	edent's Usual Occup e kind of work done DO NOT use retired	ation during most of	working		b. Kind of Bu		•
7	be filed within 72 ital Hygiene. d other than "nai event, the Wealig	dm	Elementary/Secondary (0-12)	College	(1-4or 5+)						ent Co	-	
N.	be filed tal Hygie d other event,		17. Father's Name (First, Middle,	Last)		SCHO	ol Bus Dr		Name (First, M				lucation
Maryland	d be antal	o Be	Herman W. Vosh						hine Da				
<u></u>	should by nd Menta marked umatic ev	၉	19a. Informant's Name/Relations			19b. Mai	ing Address (Street				City or Town,	State, Zij	o Code)
	as 1 and 2 should to Health and Ment item 27 is marked rother traumatic e		Barbara Voshell	(wif	e)	329	Cypress :	St. Mi	llingto	n, M	D. 216	51	
Ē,	is 1 a of Hea item othe		20a. Method of Disposition		1	b. Place of Disp	osition (Name of ematory or other place		Date	-	c. Location -		own, State
Ë	Pages nent of int: If it iry or o		1 Staurial 2 □ Cremation 1 □ Donation 5 □ Other (S)	3 □Removal from	State P		emetery		0/30/10	1	Millin	gton	, MD.
Baltimore,	permit. Pages Department of I Important: If it, any injury or o		21. Signatura Vuneral Service	1	/	i	2. Name and Addre	ss of Facility	ome of	Stepl	hen T	Sch	aoch
מ	88 1 88		100	0	MC	00510	18 West C	cross S	t. Gale	na, l	MD. 21	635	aecn
			23a. Part 1. Enter the disease, or shock, or hear failure. List	complications that	caused the d	leath. Do not er	nter the mode of dyin	ng, such as car	rdiac or respirat	ory arrest	t,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or convion	. [UNG	(ar	NON						Onset and Death
	/Medical		resulting in d th)	Due to	o (or as a	equence of):							
	Examiner		Sequentially list conditions,	b	,							_	
	ait sit	ine	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to	o (or as a con:	sequence of):							
_	and and I-tran	Examine	that initiated events resulting in death) Last	c. Due to	o (or as a con:	sequence of):						-	
8/60	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	al E			•								
8	ficate physis the	edical		d									
XON	eath certific attending p I for use as	N/u	IF FEMALE: 23b. Was decedent pregnant		utcome of pre						23d. Date	of deliv	ery
ň	death e atte d for	by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pre	birth 2 🗆 F gnant at time (□Ectopic pregnancy □ Other (s <i>pecify)</i> _				Mor	ith	Day Year
Ö.	at the de by the a stached	hys	9 □ Unknown	9□ Unk	nown								
ώ J	res tha igned be det	oy P	Part II. Other significant condition	ns contributing to	death but not	resulting in the	underlying cause giv	en in Part I.	23e.	Did toba	cco use contr	ibute to t	the cause of death?
ğ	w require been sig should t	ed						·	_	1 🗌 Yes	2 🗆 No	3 N Pro	bably 4 □Unknown
Records,	S tr	Completed							24a.	Was an	24b. V	Vere auto	opsy findings available empletion of cause of
	The ate ha	E O							10	autopsy performe (es 2 L	d? d	eath?	2 No
Vital	sician: The la certificate ha irector, page 3	Be (25. Was case referred to medical examiner?						Death (Check	only one)			90.11
0	S 0 73	၉	1 ☐ Yes 2 No			2 ER/Outpatie		4 Nursir	ng Home 5				fy)
	ing After une	i.i	27 Manner of Death 1 Natural 5 ☐ Pendin	g (Mo	e of Injury onth, Day Yea	r) 28b. Time Injury	Wor		28d. Desc	cribe how	injury occurr	ed	
<u>s</u>	Attending ir death. ector: After by the fune	icat	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r	not be	an of Injury . A	At home form		Yes 2 ☐ No	28f nca	ion (Strai	et and Numbe	or or Rur	al Route Number,
DIVISION	or A of the control of Certification:	4 ☐ Homicide determ	ined 200. Flat buil	ding, etc. (Sp.	ecify)	treet, factory, office			or Town,		or rear	ar route rumber.	
	urs urs ara		29a. Certifier 1 Certifyin	g Physician: To the	ne best of my	knowledge, dea	th occurred at the tir	ne, date and p	lace, and due to	the cau	se(s) and ma	nner as :	stated.
	To the Hosl within 24 ho To the Func completely f	Medical	(Check only 2 Medical one)		basis of examiner stated.	nination and/or i	nvestigation, in my o	pinion, death o	occurred at the	time, date	e and place, a	and due t	to the cause(s)
	To the within To the Comp	Σ	29b. Signature and title of certifie		//		29c. Licens		`~d	290	I. Date signed	1	
)					1/		DO	15178	W		1019	17/1	O
			30. Name and address of person										
			Andrew S. Ferg		_		Rd. Ches	tertown	n, MD. 2	1620			
	Sta Registr		31. Date filed (Month, Day, Year)	A 2010 32.	Registrar's Si	ignature	barker						
	negistr	aı	MOAO	4 2010	J. A. S. L. L.	1. 13							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12:26 OCTOBE Marie Del Vecchio Valenza 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Saint Leonard 2530 Garrity Road If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days (Month, Day, Year) September 19, 1926 Country) 1 M 2 X F Director Yrs. 84 577-30-4369 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 🗆 Yes 2 🔀 No Calvert Saint Leonard MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 20685 2530 Garrity Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. Yes 2 X No Completed by 1 Never Married 2 Married 21215-0036 Yes 2 No Specify: 3 X Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be land 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Iris Kernodle Samuel Del Vecchio Baltimore, Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 140 Walnut Cove Drive, Lusby, MD 20657 Kathryn Wood - daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a, Method of Disposition cemetery, crematory or other place)

Metropolitan Crematory 1 Durial 2 Cremation 3 Removal from State October 28, 2010 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sewell Funeral Home, P.A. . Signature of Funeral Service Licensee lã 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARCINOGAOF UN to Physician/ As ONTHY METASTATIC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown ed by the a detached f P.0 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ped ò within 24 hours after death.

To the Funeral Director: After this certificate has been signe completed filled in by the funeral director, page 2 should be o 1 Tes 2 No 3 Probably 4 Tunknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe Yes 2 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical **Division of Vital** Be examiner? Other: 4 Nursing Home 2 🖬 No 5 Residence 6 Other (Specify) ပု 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) injury Natural 5 Pending 1 ☐ Yes 2 ☐ No M 2 Accident
3 Suicide
4 Homicide Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29b. Signature and title of certifie

31 Date filed (Month, Day, Year)

30. Name and address

of person who completed cause of death (Item 23a) (Type, Print)

WEIGEL

32. Registrar's Signature

29c. License numbe

FREDERICK

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2010 October 14, **Physician** SHIRLEY J. WARD /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Somerset Crisfield McCready Memorial Hospital Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 03/15/1931 If Under 1 Year | If Under 2 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days Hours **Funeral** Months New York 1 □ M 2 🖾 F Vrs 79 107-22-5610 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "facial Examinar must be rectified at once. 1 Yes 2 No Richmond Virginia Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 23225 6501 Jahnke Rd. - Apt. 204 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give Specify: Black 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 🖾 Divorced 2 Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Employment Commission Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alena Sarah Prime William Ward ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Done Lla Smith — 323 North Blvd. — Petersburg, VA 23805
Rhonda Ward — 2804 East Leigh Street — Richtond, VA 23223 19a. Informant's Name/Relationship (Type. Print) (Children) Donella Smith & Rhonda Ward 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 10/14/2010 Delmar, Delaware Crematory of Delmarva 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility BW DSHAW & SONS FUNERAL HOME 21. Signer of Foural Victorians

Mary Beth Bradshaw-Pruitt 306 W. Main Street - Crisfield, Maryland 21817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed and burial-tran Due to (or as a consequence of): attending physician for use as the buria Box 68760, Physician/Medical 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.O.1 ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【 Unknown Division of Vital Records, þ page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 □ No 2 No 1 ☐ Yes 1 ☐ Yes certificate 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? funeral 27. Manner of Death After t To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 5 ☐ Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No M 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 14, 2010 D 48098 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vijay Karumbunathan, MD - 201 Hall Highway - Crisfield, Maryland 21817 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death October 1:00am Physician/ Ruth Whitsitt 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Manor Care of Silver Spring Silver Spring 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. **Funeral** (Month, Day, Year) 26 Days 1 🗆 M 2 🕱 F Months Hours North Carolina 84 Director 372-22-1153 Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 X No Silver Spring Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 20904 2501 Musgrove Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Cafeteria Worker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Carrie Logan Rexford Wood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dermit. Page 1 and 2 st Department of Health at Important: If item 27 is any injury or other trau Lane, Laurel, Maryland 20724 3231 Purple Leaf <u> Linda Whitsitt - Daughter</u> 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place 1 🔀 Burial 2 🗆 Cremation 3 🗓 Removal from State 10/15/2010 Scotch Plains, NJ Hillside Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 21. Signature of Funeral Service Licenses 1800 New Hampshire Ave., Silver Spring, MD 20904 1/CUA 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardial Infarction Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of Examine signed by the attending physician and deed be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 X No Day Year Month Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 X No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 X No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 X No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) ျပ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

24 hours after death.

Funeral Director. After this certificate has eted filled in by the funeral director, page 2: Hospital within 2 To the I 5

> State Registrar

Medical

29a. Certifier

only one)

29b. Signature and title of certifier

Victor Onyejiaka.

Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD.

DHMH 17 Rev 7/2009

1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

4115 Wilkens Avenue, Baltimore, Maryland 21229

D46529

29d. Date signed (Month, Day, Year)

October 12, 2010

Amend #5, per FD, Please Type or Print in Black Indelible hak Introduce Are Legible.
State of Maryland / Department of Health and Mental Hygiene 10/28/2010, CCHD, drw for State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ October 2010 9:15 A^{M} Ellen Whittington Virginia Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Dunkirk <u>4022 Yellow Bank Road</u> 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 92°119°ecurity4\um2°636 **Funeral** Days 1 □ M 2 👿 F Hours Min. 05-06-1914 Mary Tand Director 96 Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State should be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No MD Calvert Dunkirk 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 4022 Yellow Bank Road 20754 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 3 X Widowed 4 Divorced white Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) d Mental Hygiene marked other tha 12 homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rose Ε. Lee Mordie Brady and l 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 4022 Yellow Bank Road, Dunkirk, MD Clifton O. Whittington, Jr, son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Smithville Cemetery 10-19-2010 Dunkirk, MD 22. Name and Address of Facility Rausch Funeral Home, P.A. Signature of Fyneral Service Licenses 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Sever Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a compequence Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cardiovascu No 3 Probably 4 Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of autopsy perforn death? 1 Yes 2 No Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 24 hours after deatle Funeral Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier within 2 To the I only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0027189 October 18, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Solomons Island Road OUSAF 10 31. Date filed (Month, Day, 32. Registra State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ebecca L. Thrasher Williams 1610 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Maryland Regional Medical Cente Cumberland Allegan 6. Sex 1 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🖾 F Months Days (Month, Day, Ye, West Virginia Yrs. Director 59 213-58-8528 Ĩ951 Usual Residence of Decedent show 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Allegany Cumberland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12316 Williams Road, SE 21502 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Bowling Supply Company Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Page 1 and 2 should be Chester Pau1 Sr. Kenney, Ethe1 Louise Barnett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 12316 Williams Road, SE., Cumberland, MD. 21502 Herbert Williams/Spouse 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. 10/11/2010 | Alexandria, Virginia Signature of Funeral Service Licens 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ END STACE CHRONIC OBSTRUCTIVE LUNG disease or condition Medical resulting in death) Due to (or as a consequence of Examiner 5 121 0152ASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence on and I-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial physician sthe burial Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death Year 2 No 9 Unknown 9 Unknown þ been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed page certificate 2 🗌 No Yes 2 N 1 Yes Hospital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Hospital Other: 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c, Injury at Certificate: 28d. Describe how injury occurred Natural injury 5 Pending hours after death. neral Director: After dilled in by the fur 2 Accident 3 Suicide 4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined To the Hospital within 24 hours a To the Funeral C completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

12

Maryland 21215-0036

Baltimore.

Box 68760

P.0.

Records,

Division of Vital

Street.

200 Glenn

Registrar's Signate

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robustiano Barrera

14865

Suite 302, Cumberland,

77+

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-07782 Rory Joseph Weichbrod State of Maryland / Department of Health and Mental Hygiene 2010 34687 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day October 10, 2010 Rory Joseph Weichbrod **Medical Examiner** 4a. Facility Name (if not institution, give street and number)
HOSDITAL
Suburban-Hispital Town, or Location of Death thesda 4c. County of Death Montgomery 7. Age (In yrs. last birthday) If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex If Under 1 Year **Funeral** Min. Months Days Hours 218-13-9022 Sept. 16, 1984 Director 26 Country) 1 X M 2 F Yrs Usual Residence of Decedent апу 10c. City, Town or Location 10a, State 10b. County ta or 28a-f show Silver Spring MD Montgomery Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If them 27 is marked other than "natural", or items 23a or 28a-f sho or other tranmatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 123 Lexington Drive 20901 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 1 Yes White 1 Yes 2 No specify: 4 Divorced f Yes, Give Year Specify: <u>م</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Fine Wines Sales Representative 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) Kathleen Gallagher 17. Father's Name (First, Middle, Last Robert H. Weichbrod Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ဥ 123 Lexington Drive, Silver Spring, MD 20901 Robert H. Weichbrod/Father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State timore, 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 2010 Alexandria, VA Donation 5 Other Specify: 21. Six ure of Funeral Syrvice Lice. 22 Name and Address 1941 Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 art I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line /Medical a Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed attending physician and or use as the burial - tran Physician/Medical UNPENDED AMENDED 4a/boerME, 10/18/10, EMW, McCo Box 68760, IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o ۾ 1 Yes 2 ✔ No 3 Probably 4 Unknown Completed Records, Were autopsy findings available 24a. Was an autopsy prior to completion of cause of has death? performed? 1 🗸 Yes ✔ Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other Nursing Home 5 Residence 6 Other Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 DOA ို 1 Yes 2 No

this certificate To the Hospital or Attending Physician: of Vital After Division death. Director: within 24 hours after To the Funeral Dire

Certification:

State Registrar

Manner of Death

Homicide 29a. Certifier 1

29b. Signature and title of certifier

Donna M. Vincenti, MD

5 Pending

6 Could not be

Investigation

determined

1 Natural

2 🗹 Accident

3 ___ Suicide

28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Pedestrian struck by auto 1 Yes 2 ✓ No 28f. Location (Street and Number or Rural Route Number, City 28e, Place of Injury - At home, farm, street, factory, office building, etc or Town, State) Rt 355 and Marinelli Drive, Rockville, MD Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) October 12, 2010 O.C.M.E. 111 Penn Street, Baltimore, MD 21201

3. Time of Death

0343 hrs

10d. Inside City Limits

1 Yes 2 XNo

Approximate Interval

Between Onset and

Death

Year

0315 hrs

30. Name and address of person who completed cause of death (Item 23a)

28a. Date of Injury

and manner stated

Oct 10, 2010

(Specify) Local Street

Assistant Medical Examiner

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year 9:43 A 2010 October 13, Dorothy Wiggins 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Takoma Park Montgomery Washington Adventist Hospital Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Months Days Hours Min. 1 □ M 2 🔀 F 86 21, DC 1924 577-34-7369 May Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 X Yes 2 No Washington DC 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20001 United States 1004 S Street NW 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: African 1 ☐ Yes 2 🗷 No Specify. 3 X Widowed 4 ☐ Divorced American 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Government Housekeeper 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Edwards Martha Edwards 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8313 Hillview Road Landover, Maryland George Ford - Son 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition October 21, 1 Burial 2 □ Cremation 3 □ Removal from State Landover, Maryland Harmony 2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Stewart Funeral Home, Inc. NOW 20019 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): TEMSION Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) PABETES MELLI Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day Month Year Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown autopsy

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

show

28a-f

23a or

items

0

"natural",

than

s 1 and 2 should be filed wi f Health and Mental Hygier item 27 Is marked other th

permit. Pages 1 an Department of Heal Important: If item 2 any injury or other

Director

Funeral

þ

Completed

Be

ပ

injury or other traumatic event, the Medical Ever insert aust be notified at

death with the Maryland

72 hours after

Baltimore, Maryland 21215-0036

burial-transit and the as nse for cate has been signed by the page 2 should be detached certificate funeral director, this To the Hospital or Attending I within 24 hours after death, To the Funeral Director: After

law requires that the death certificate be executed

Box 68760.

P.O.

Division of Vital Records,

Examine Physician/Medical ģ Completed Be Certification: To filled in by the

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No

performed 1 ☐ Yes 2 ☑ No 26 Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical		26. Place of Death (Check only one)
examiner? 1 ☐ Yes 2 🗷 No	Hospital: 1 ☐ Inpatient 2 ☑ ER/	Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specif
27. Manner of Death 1 Natural 5 □ Pending		b. Time of 28c. Injury at 28d. Describe how injury occurred lnjury Work?
investigation		M 1 □Yes 2 □No

2 Accident 6 Could not be determined 3 Suicide 4 ☐ Homicide

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

29a, Certifier

OCT 2 0 2010

State

Registrar

completely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 October Ρ. Wilsie Wallace Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington 1361 Outer Dr. Hagerstown Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral 1 □ M 2 🔀 F Hours (Month, Day, Year) 3/19/1.917 Director 93 260-12-6026 Georgia Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ¥Yes 2 □ No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Outer Dr. 1361 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Logistics Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dr. James Cleavland Poss Atossa Morris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Outer Dr. Hagerstown Maryland 21742 Barbara Dutton / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Rest Haven Cemetery 10/23/2010 Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave Hagerstown Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause the each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 2 No n signed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ lenosell 2 No 3 Probably 4 Unknown Completed certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? 1 Yes 2 No we gr 2 No Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **X**No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 623

4-40 State

DHMH 17 Rev 7/2009

Registrar

III ms 11110 medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

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Us town

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		State Registrar A ^{TI} 1. Decedent's Name			erali	lome1	0/2 <u>19</u> 9	20106	edona	gairi		2. Date of De			0	3. Time of Death
Physicia Medic		Annama			Elizab	eth W	indsor					Oct 16.	2010		'ear	1:50 A M
Examin	er	4a. Facility Name (if		-				1	, Town, or Clinto	Location of	f Death			. County of Prince		rao!a
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show dat	tor	10a. State	10b. County			10c. Cit	y, Town or L	ocation							1	0d. Inside City Limits
e Mary 28a-f notifie	Jirec	Maryland		George's	3		Clin		- 0-1-							1 Yes 2 No
with the 23a o	Funeral Director	10e. Street and Nun		6 Gwyndal	e Driv	10f. Zip Code e 20735							10g. Ci	tizen of Wh Unite		
items	Fun	11. Marital Status		12. Was		Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes of Yes, specify Cuban, Mexican, Puerto Rican, etc.)						cify Yes or No- Rican, etc.)	or No- 14. Race - Ameri			an Indian,
al", or	d by	1 Never Marri		ried 1 🗌	Yes 2XX s, Give or Dates.						,		Specify:	Whit		
hours hatur dical E	Completed		15. Decede	nt's Education est grade comp		16a. Decedent's Usual Occupation (Give kind of work done during most of working						16b. K	(ind of Busi	ness Inc	dustry	
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.		21. Signatur of Fu	neral Service	icensee	MU	139							Home,	Inc 6	533 (Old Alexandria
		23a. Part 1. Enter t		complications only one cause	that cause	d the deat				Clintor g, such as c			rrest,		Т	Approximate
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ding F th. After funer	cate	27. Manner of Death 1 Natural 2 Accident	5 Pendi	ng	Date of inju (Month, Da		28b. Time injury	M I	28c. Injun work 1 🏻			8d. Describe	how injui	y occurred		
3 Suicide 3 Suicide 4 Homicide determined 286. Location (Street and Number or Rura building, etc. (Specify) 286. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 287. City or Town, State)												or Rural	Route Number,			
										ac ctate						
n 24 ho	Medical	(Check 2	Medical I		ne basis of e	examination	n and/or inve	estigation, in	my opinio	on, death occ	curred at	the time, date	and place	e, and due to	the cau	use(s) and manner stated.
To the To the Comp	-	29b. Signature and	title of certifie	r	0/,	0	?	29	c. License	e number	700	\hat{z}		ite signed (
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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10f&19b G909 11/18/10 JH
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Month Day Charles E. Anders, Jr. Nov 2010 $10:00P^{M}$ Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 7610 Poplar Avenue Dundalk Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 1 XM 2 □ F (Month, Day, Year) Days Hours Min 215-66-3210 Yrs Director 54 MD Usual Residence of Decedent 28a-f shov 10a. State 10h County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Baltimore Dundalk 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21224 with 7610 Poplar Avenue 21222 USA Was Decedent L. Armed Forces?

1 Layes 2 Nofter After 55 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian, Black. White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 hours after 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other th Dye Maker Manufacturing permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event; Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles E. Anders, Sr. Margaret Wise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Boute Number, City or Town, State Balto Barbara Anders - Wife 7610 Poplar Ave. Dunda: 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Holly Hill Cem. 1 X Burial 2 Cremation 3 Removal from State 11 - 8 - 10Middle River, 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bradley-Ashton Funeral Home 2134 Willow Spring Road, 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ESUPHAGIAC METASTATEC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine cause. Enter Underlying Cause (Disease or linjury Due to jor as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed lifted in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performe 1 Yes 2 No Yes 2 25. Was case referred to medical examiner?

1 Yes 2 Yo Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending injury Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Cartifying Nursa Praction or: To the cost of my incovince, death occurred at the time, date and place, and due to the cause(s) and manner stated

Cartifying Nursa Praction or: To the cost of my incovince, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

**** DHMH 17 Rev 7/2009

State

Registrar

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PHILIP NIVATPUMBL

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month CTOBER Physician/ Day 28 AIDA CONCETTA BREEN 2010 12:00 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Sunrise Assisted Living Anne Arundel Severna Park | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Month | Days | Year | 2 3 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 1 M 2 K F 216 16 8884 87 Yrs. Director NY Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Pasadena 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8259 Spring Knoll Dr. 21122 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 11 Salesperson Bridal Shop Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Pasquale Romano Santa Caronnati 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3102 Aida Cipriani - daughter Drogue Ct Annapolis, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Cross Cem 2 2010 11 Baltimore, 22. Name and Address of Facility GJ Gonce Funeral 21. Signature of Funeral Service Licensee 169 Riviera Dr Pasadena, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Priysician/ EAST CARCINOMI Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause Error Underlying Examine Due to (or as a consequence of): and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): ned by the attending physician a detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by s been signer 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an certificate has page 2 perform within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 Vo Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 은 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 Yes 2 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 💢 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8601

DHMH 17 Rev 7/2009

Veterano

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ Hayden G. Braine 2010 October 7:10 AM M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Hospice Towson Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Funeral ^{Year)} 1943 Days Hours Min (Month, Day, July 5 1 X M 2 □ F Months Connecticut Director 049-32-0129 67 Usual Residence of Decedent or 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2√ No Baltimore MD Monkton 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? 2132 Corbett Road 21111 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No
If Yes, Give
Year or Dates.

174-76 Black White etc. ģ 1 Never Married 2 X Married "natural", or Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 physician healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Sarah Elizabeth Hayden John Hamilton Braine permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic to 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2132 Corbett Road Monkton, MD Beverly B. Braine/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wade State and detentation of the street Director mon Baltimore, MD 21201 23a. Part 1 Enter the diseas , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, leart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Frontotana disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to inmediate cause. Enter Underlying Due to (or as a consecremos of): Examir Cause (Disease or linjury that initiated events resulting in death) Last tran and Due to (or as a consequence of): physician a Physician/Medical death certificate be as attending use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown ō Month Day Year Pregnant at time of death ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I ð 1 ☐ Yes 2 ☐ No 3 🔼 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe certificate Yes 2 N Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 1 ☐ Yes 2 🗷 No ျှ 1 Inpatient 2 ER/Outpatient 3 IDOA this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death n 24 hours after death.

e Funeral Director. After the pleted filled in by the funeral 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 🗹 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) 2000 71040 30 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

68760

Box (

P.O.

Records,

Division of Vital

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

32. Registrar's Signature

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STREFT

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 0 1 0 3 4 5 9 5 State of Maryland / Department of Health and Mental Hygiene

		I-For State Certificate of Death		Reg.	No.				
Physician Medical Examine	/	1. Decedent's Name (First, Middle,Last) JEREMIAH JOSEPH BROWN	N	Date of Death Month D November 1		3. Time of Death 1930 hrs			
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, Orchard B	or Location of Death Beach		4c. County of Death Anne Arundel				
Funeral Director	-	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 You Months Day 1	ear If Under 24Hrs. ays Hours Min.	–	MM/DD/YYYY) 9. Biri 1979 Foreig				
ow any		Usual Residence of Decedent 10a. State				10d. Inside City Limits 1 Yes 2 No			
the Maryland a or 28a-f show any tified at once.	li ector	MD Anne Arundel Orchard Beach 10e. Street and Number 10f. Zip Code 8231 Parkway Road	21226		Citizen of What Cour	ntry?			
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. In the Maryland Hygiene, I file marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once, To Bo Completed by Enmeral Director		can Indian, Black,							
tours after of autural", or xaminer m	Specify: What is the second of Business/I	nite							
5-0036 ed within 72 hour hygiene. other than "natte the Medical Example of the Completed Complet	naldiilo	Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) Actor/Come	edian	(First, Middle, Mai	Enterta	inment			
ould be filed within 7 Mental Hygiene. A Mental Hygiene. S marked other than it event, the Medical		Joseph Howard Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Str	Grace	Ann Br	unk	, Zip Code)			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene, Important: If item 27 is marked other than 'injury or other traumatic event, the Medical	-	Joseph H. Brown - father 8231 Parkw 20a. Method of Disposition 20b. Place of Disposition (Name of C	ray Rd (Orchard Date 2	Beach, 1	MD 21226 Town, State			
Baltimore, MD remit. Pages I and 2 sho permit. Pages I and 2 sho Department of Health and I himportant: If item 27 is injury or other traumati		4 Donation 5 Other Specify: Meadowridge Me	em Pk 11/	/5/10 Gonce	Elkridge Funeral	Home, PA			
Physician	+	23a. Part VEnter the disease, or complications that caused the death. Do not enter the mode of dyin failure. List only one cause on each line.	iera Dri	ve Pas	adena, M	Approximate Interval Between Onset and			
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Contact Gunshot Wound of Head Due to (or as a consequence of):				Death			
		Sequentially list conditions, if any, leading to immediate cause. Enter U Johny'ng Cause (Disease or injury that initiated							
760, icate be executed physician and the burial - transit	EXE Cal EXE	events resulting in death) Last Due to (or as a consequence of): d. UNPENDED AMENDED	· · ·						
	Priysician/wed	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 4 Pregnant at time of death 5 Other (Specify)	3 Ectopic pregna	incy	23d. Date of delivery	Oay Year			
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certificate the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as to defined.	<u>a</u>	1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause	e given in Part I.		cco use contribute to	the cause of death?			
cords, e law require e has been si ge 2 should b	Completed			24a. Was an autopsy performe	prior to death?	topsy findings available completion of cause of			
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f Vital Physician or this certi	٩L	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA			esidence 6 🗸 Other	: Scene			
ivision of or Attending P after death. Director: After d in by the funera	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 3 Suicide 6 Could not be determined 6 Could not be determined 6 Subject shot self 28b. Time of Injury 1900 hrs 1 Yes 2 No 28b. Time of Injury 1900 hrs 1 Yes 2 No 28b. Time of Injury 1900 hrs 1 Yes 2 No 28b. Time of Injury 1900 hrs 1 Yes 2 No 28b. Describe how injury occurred Subject shot self 28b. Describe how injury occurred Subject shot self 28b. Describe how injury occurred Subject shot self 28b. Describe how injury occurred Subject shot self 28c. Injury at Work? 1 Yes 2 No 28b. Describe how injury occurred Subject shot self 28c. Describe how injury occurred Subject shot self 28c. Describe how injury occurred Subject shot self 28c. Describe how injury occurred Subject shot self								
Divis Divis Ospital or A hours after inneral Direct y filled in b									
To the Hospita within 24 hours To the Funeral completely fille	Check only 2 Medical Examiner: On the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. We dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)								
			C.M.E.		November 2, 20	10			
		Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Stree	et, Baltimore, M	D 21201					
Stat Registra	te ar	31. Date filed (Month Cay, Year) 2010 32. Segistrar's Signature flavors of the segistrary signature fl							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NW MEDEDAY3 JOHN BROWN Physician/ :15 AM 1010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Nuising Home Longville If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Sep. 2, 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 M 2 🗆 F Months Hours Country) Maryland 216-30-3213 Director Sep. 1933 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "---- any injury or other then." 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director XX Yes 2 No Maryland Carroll Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States Funeral 4207 Ralph Avenue 21074 America 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. ģ 1 Never Married XX Married 1 ☐ Yes 2XXNo Specify: If Yes Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore Gas & Elementary/Seconday (0-12) College (1-4 or 5+) 12th Customer Service Rep. Electric Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John Herring Brown Estie E. Leister 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Yingling (Daughter) 3789 Castle Drive, Hampstead, Maryland 21074 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Nov. Date 6, cemetery, crematory or other place) 1XXBurial 2 Cremation 3 Removal from State New Lutheran Cemetery 2010 Manchester, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility FUNERAL LAMPEL Signature of Fundal Service License 21102 MANCHESTER 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause are each line. Approximate Interval Between Immediate Cause (Final Ph, sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transit Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ned by the atter in the past 12 months? Day Month Year signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CardioVascular 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate is completed filled in by the funeral director, page 2 🗌 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 2 A No 1 Yes Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗔 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month. Day, Year) 11/03 BECKEYSVILLE 31. Date filed (Month, Day, Year) State 0 5 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 34697 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 2014 PM Marie Frances Brown 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Rosedale FRANKLIN Sauare Hospital 7. Age (In yrs. last birthday) If Under 1 Year | (f Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F Months Days Hours 0771671948 Maryland **Director** 62 214-52-8921 Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Essex 1 Yes 2 XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō traumatic event, the Medical Examiner must be 23a Funeral with 172 Wiltshire Road 21221 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. 0, Completed by 1 Never Married 2 Married ☐ Yes 2 XXNo 1 Yes 2XXNo Specify: If Yes, Give Year or Dates Specify: "natural" 3 Divorced 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit, Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 Nurse Hospital Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Albert Seebode Barbara Rettman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 172 Wiltshire Road, Essex, Maryland 21221 James Brown, Sr. (Husband) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1XXBurial 2 Cremation 3 Removal from State Sacred Heart of Jesus 11/08/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fundal Feet e Licensee 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A <u> 1407 Old Eastern Avenue, Essex, Maryland 21221</u> 23a. Pa 💹 Latter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Im Ediate Cause (Final die ase or condition esulting in death) Physician/ enic Shock cardioa Medical Due to (or as a consequence of): Examiner Electrical Activity Cardiac Arrest Pulseless Sequentially list conditions. Examine rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury atherosclerotic disease requires that the death certificate be executed for use as the burial-transi coronary vasular and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) s been signed by the sahould be detached 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by severe anemia Records, 1 Yes 2 No 3 Probably 4 Unknown Obesily 24a. Was an 24b. Were autopsy findings available page 2 prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perform Yes 2 No or Attending Physician: The certificate Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) director, examiner?
1 Yes 2 No Hospital: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Qertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3

Registrar DHMH 17 Rev 7/2009

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13 31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signăture

Samile

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FRANKLIN SQUARE DR

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		•	For State Registrar	State of Maryland / t	Certificate of E		rentai mygie Reg.		
	Physicia		1. Decedent's Name (First, Middle, Last) Marion B. Burg	ess			2. Date of Death Month November	Day 4 2010	3. Time of Death 10:00 a _M
	Medic Examin		4a. Facility Name (if not institution, give str Gilchrist Hospice	eet and number)	4b. City, Town, or Towson	Location of Death	- INO VEMBER	4c. County of Death Baltimore	e
	Funeral Director		5. Social Security Number 6. Sex 1 -	M 2 🕅 F 83		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye. Nov 18	9. Birthr	place (State or Foreign
	Maryland 28a-f show otified at	rector	Usual Residence of Decedent	10c. City, Towr Sykesv	or Location ille			1	0d. Inside City Limits
	with the s 23a or 3 ust be no	eral D	10e. Street and Number 1050 Sunset Valley	Drive	10f. Zip Code 21784	+	10g	. Citizen of What Coun USA	try?
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ted by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates.	13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🏋 No		cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, 6 Specify: Whit	etc.
21215-0036	vithin 72 hor jiene. er than "nat the Medica	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Seconday (0-12)	Completed)	Decedent's Usual Occupi (Give kind of work done of life. DO NOT use retired) elephone ope	luring most of working	ng	b. Kind of Business Inc telecommun	
Maryland 2	d be filed v Mental Hyg arked othe	To Be	17. Father's Name (First, Middle, Last) Gordon Gray	'		18. Mother's Name	Fling	den Surname)	
, Man	d 2 shoul ealth and I n 27 is ma er trauma		19a. Informant's Name/Relationship (Type Mr. Eugene F. Burg	Print) gess (spouse) 10	. Mailing Address (Street a 950 Sunset Va	alley Dr.	Route Number, Cit , Sykesvi	ty or Town, State, Zio C 11e, MD 21	784
Baltimore,	Page 1 an ment of He ant: If iten ury or othe		20a. Method of Disposition 1 ABurial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State Carris	f Disposition (Name of ry, crematory or other plac SON FOREST Ve	et. 11-15		c. Location - City or To Wings Mill	
Balt	permit. Departimport any inj		21. Signature of Funeral Service Licensee	Herbert	22. Name and Address P.O. Box 19		-	al Home & 21784	Chapel
3	h, sician/ Medical Examiner	2 5	23a. Part 1. Enter the disease, or complic shock, or heart fallure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the death. Do not cause on such line. Due to (or as a consequence of	Lu Cou	g, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
00	cate be executed physician and the burial-transit	Aedical Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or iinjury that initiated events resulting in death) Last d.	Due to (or as a consequence of					
. Box 68760	the Hospital or Attending Physician: The law requires that the death certificate be executed that 4 hours after death. Lid 4 hours after death. the Funering Infector: After this certificate has been signed by the attending physician and the funering interest of the funeral director, page 2 should be detached for use as the burial-transical properties.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	n 3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		23d. Date of delive	ery Day Year
ds, P.O.	requires that the been signed be should be deta	ò	Part II. Other significant conditions cont	ibuting to death but not resulting i	n the underlying cause giv	en in Part I.		co use contribute to the	.
Recor	The law requi	Completed					24a. Was an autopsy performed	prior to co	psy findings available mpletion of cause of
/ital	Physician: The this certificate al director, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital:	Othe	ace of Death (Check		A	Mara'. O
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The second of the state of the									Route Number,
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completed filled in by the fu	Medical	(Check 2 Nedical Examine	an: To the best of my knowledge, On the basis of examination and/o	r investigation, in my opinio	n, death occurred at	the time, date and p	lace, and due to the cau	use(s) and manner stated.
	To th within To th		29b. Signature and title of certifier	_ M.D.	29c. License	number 71287	29d.	Date signed (Month, I	Day, Year)
<u>6</u>	,		30 Name and address of person who com	4.6701 N.C	Type, Print)	Suite	+105,BE	Much	40116 MD
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	1 Laike		•		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Physicia ledical Exami	an/	1. Decedent's Nam							2. Date of D Month October	eath Day	Year	3 Time of Death 2054 pm
redical Exami		4a. Facility Name	if not institution	Burks n, give street and nu	mber)	- 1	4b. City, Tow	n, or Location of De		4c	. County of Dear	
		125 Twin C					Haletho	·	la D-4		Saltimore Co	
Funeral Director		5. Social Security 212 41		6. Sex	7. Age (In yrs. Ia	ast birthday)			Min.	.5,1	Fore	irthplace (State or ign ountryMD
		Usual Residence of	f Decedent							• • • •	775	
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Maryland 28a-f show any d at once,	Director	10e. Street and Nu 3406 E.	mber				10f. Zip Co	de 21212		10g. Citi:	zen of What Cou	untry?
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eath wit items 2 ust be n	Funeral	11. Marital Status 1 X Never Mari	ed 2 Ma	Armed Fo				of Hispanic Origin? uban, Mexican, Pu		No-	14. Race - Ame White, etc.	rican Indian, Black,
after de	J. F.	3 Widowed	4 Dive	1 Yes orced If Yes, Give Yea or Dates:	2 ∑ No ir	1		No specify:			Specify: Bl	
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212 ould be d Ment; s mark itc even	To B	19a. Informant's N	ame/Relationsl	nip (Type, Print)	reer			Street and Number		lumber, Ci	ity or Town, Stat	
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Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thingry or other traumatic event, the Med		4 Donation 5	Other Spuneral Service					dress of Facility Scrug				
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Physician - Medical		failure. List or	nly one cause	on each line. a. Gunshot W				,g,	,		•	Between Onset and Death
Examiner		or condition result			consequence of							
	Jer	Sequentially list of if any, leading to it cause. Enter Und	nmediate	Due to (or as a	consequence of	f):						
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60, ate be e: hysiciar e burial	Medical	IF FEMALE:		XX #	10e.f.17-	-19b, pei	INF/FH	.G909.11/	17/10.WS	230	d. Date of delive	Try
Box 68760, e death certificate be the attending physic ed for use as the bur	ian/	23b. Was deceden past 12 month	t pregnant in th s?	e 1 Live b		2 Fe	etal death	3 Ectopic pre	egnancy		Month	Day Year
Box le death the atte	Physician/M	1 Yes 2	No 9 Unk	g Unknown		5 0	ther (Specify)	<u> </u>				
P.O.	à	Part II. Other sign	ificant condit	ions contributing to	o death but not re	esulting in the	underlying ca	use given in Part I.		_		o the cause of death?
prds, P w requires t s been sign should be o	Completed	-							24a. W	as an		utopsy findings available completion of cause of
Cecol	dmo	•							pe	rformed?	death?	
tal Rec	BeC	25. Was case refe examiner?	rred to medical	Hospital:				Place of Death (Ch				
n of Vi Jing Physi After this funeral dir	욘	1 Yes 27. Manner of Dea	2 No	28a. Date	Inpatient 2 of Injury	ER/Outpatien 28b. Time of		. Injury at Work?	ursing Home 5		ence 6 🗸 Other	er: Scene
ion trendin leath tor: A tree fur	ation	1 Natural 2 Accident	5 Pend	ling Oct 31,	, Day Year) 2010	1845 hrs	1	Yes 2 ✓ No	Subject s	hot		
23c. If yes, outcome of pregnancy 23c. If yes, outcome of death 23c. If yes, outcome												
Hospital 24 hours Funeral tely fillec		4 Homicide 29a. Certifier (Check only 1	1	nysician: To the bes			rred at the tin	ne, date and place,				
To the within To the complet	Medical	one) 2 🗸		miner: On the basis and manner s		nd/or investiga			red at the time, da			
	2	29b. Signature an	a due of certifie					cense number			Date signed (M ember 1, 20	
				who completed cau	se of death (Item							
		Laron Lock		ssistant Medica	al Examiner egistar's Signatu			altimore, MD 2	21201		 	
S Regis	tate			× 2010	Salaria Signati	1	barke	/				

DHMH 17 Rev 1/2001 OCME 2006

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Items 28a-f per me, g909, 11,04/2010dhb
Certificate of Death

Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ DARAH ILL Medical OPTEMBER 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE -CHRIS If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Mgnth, Day yrs, last birthday) **Funeral** Days 1 DM 2 ZF **Director** permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. Cour 10d. Inside City Limits **Funeral Director** 1 Yes 2 No 11. Marital Status Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 2 No 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Completed 3 ☑ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be ည 20a. Method of Disposition Place of Disposition (Name 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) of Funeral Service Lice Signatu Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. 23a. Part 1. Interval Between Immediate Cause (Final nset and Death Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) CERTIFICATION APPROVED BY MELICAL EXAMINER Examiner Sequentially list conditions. Examiner any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence bij. physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate been signed by the attending p should be detached for use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use convolute to the cause of death? Completed by DIABOTES MELLITUS 1 Yes 2 No 3 Probably 4 Unknown OBSTRUCTIVE PULMONARY DISEASE 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy TH MULTIPLE FRACTUROS performed Yes 2 death? this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 🗆 No ပ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28d. Describe how injury occurred fell from 28c. Injury at eral Director: After filled in by the funer 1 Natural
2 Accider 5 Pending 08/19/2010 **Unknown**_M first story window 1 Yes 2 X No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Sister s home 28f. Location (Street and Number or Rural Route Number, City or Town, State)722 Tinker Road, determined 24 hours a Essex, MD ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practicular: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year

RON MI

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene 27,28a-f per me, g909.11/04/2010dhb
Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 27, 2010 Charles Mariner Cole, Jr. 11:35 Ам Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Days Hours November 14, 1920 Rhode Island 035-16-7092 **Director** Usual Residence of Decedent 28a-f shov death with the Maryland 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Maryland Montgomery Rockville 1 X Yes 2 ☐ No 9 10e. Street and Number 10g. Citizen of What Country? 23a 14431 Traville Garden Circle, #D202 20850 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 □ No WWII If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married 1 Yes 2 X No Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 3altimore, Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) the Regional Sales Manager Insurance 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Mariner Cole, Sr. Carrie Booth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret S. Cole / Wife 14431 Traville Garden Circle, #D202, Rockville, Maryland 20850 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium. Inc. 20a. Method of Disposition 20c. Location - City or Town, State 1 🗆 Burial 2 ី Cremation 3 🗆 Removal from State October 31, Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 21. Signature of Fundral Service bicensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850—2805 M01305 23a. Part 1/Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory viest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician. disease or condition resulting in death) BOWEL SMALL DASTRUCTION Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): 10 Completed by Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Yes g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown dementio 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 ☑ No the Hospital or Attending Physician: The 2 🗌 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 1 Yes 2 1 No Other: 1 Npatient 2 ER/Outpatient 3 DOA ျ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury_at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 10/20/2010 **Unknown** M Subject fell. 1 Tes 2 X No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 14431 Traville Garden Circle, #D202, Rockville, MD 4 Homicide determined Home Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. . Kane MD harane OCTOBER, 27th, 2010 D068178 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 MEDICAL RANE CENTER DRIVE ROCKVILLE MARYLAND State

DHMH 17 Rev 7/2009

Registrar

2010

OCTOBER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5perFH, G909, 11/3072010, WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10 Year / 2:15 AM Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Care Home INDOA Baltimore Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 78 Yrs. Funeral 1 M 2 KF Months Director 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health anc Mental Hygiene. Important: If item 27 is nighted other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits Funeral Director Kaltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Street 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) conday (0-12) College (1-4 or 5+) Disablea Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, ဂ္ 19a. Informan 20a. Method of Disposition
1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Denation 5 Dother (Specify of Fun a Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical **Examiner** umonia Sequentially list conditions, if any healthy to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 🗌 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 X NO Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) PHYSICIAN 11-2-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PREETINDER SANDHU 940 W. BALTIMORE ST BALTIMORE, MO 21223 MD 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

			Amend Items 4a,23						Reg. No.		0 0
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)	Examin		4e Facility Neme (If not institution, give	street and number)	The V	illa	4b. City, Town, or	Location of Deet	h 4c. County	of Death	
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	Funeral Director		214-20-3/33	ex 7. Age (I ☐ M 21区 F	ln yrs. last bi 82	irthdey) If Under 1 Yea Months Days			rth ay, Yeer) 1927	9. Birthplace (Sta Country) Pennsylva	-
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Maryland 21215-0020	72 hours after death with the Marylend natural', or fleme 23e or 28e-f ehow deal Examiner must be notified at	by Funeral Director	11. Marital Status 1 ⊠ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	er in U,S.	13. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ No	ban, Mexican, Puer	Specify Yes or No to Rican, etc.)	9- 14. Rad Blad Specify	ce - American Indiar ck, White, etc. y: White	1,
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	and 2 sho ealth and n 27 is me					rel Route Number, City or Town, State, Zip Code)					
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Baltimore,	permit. Departr Imports any inje		21. Signature of Funeral Service Licens Ronald S. V	Nade frigg	tor	22. Name and Addr	ess of FacilitySta Saltimore				•
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1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician 11.20 AM Erma K. Cunningham JOV 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Augsburg Lutheran Home Baltimore Baltimore If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (Country)
Sept. 7, 1920 Maryland Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2 🖵 F 212-10-8208 Director 90 Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show injury or other traumatic event, the Medical Evaminar must be notified at 1 ☐ Yes 2 X No Funeral Director Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? , or Items 23a or USA 6811 Campfield Road 21207 Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 ☑No Specify Specify: white <u>چ</u> 3√2 Widowed 4 ☐ Divorced Year or Dates "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Housewife At Home 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be if Health and Mental item 27 is marked of Edna Breeden ၉ George Knepper 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1106 East36th Street-Baltimore, Maryland 21218 Wilbur Cunningham-son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)

Darlington Cemetery 20a. Method of Disposition Date permit. Pages 1 Department of F Important: If ite any injury or ot 1 → Burial 2 Cremation 3 Removal from State Nov.5,2010 Darlington, Maryland 4 Donation 5 DOther (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services · ondrae 8800 Harford Road-Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. □Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2, No 1 □Yes 2 1 No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending 1 □Yes 2 □No within 24 hours after death.

To the Funeral Director: A investigation 2 Accident 6 ☐ Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

State Registrar **DHMH 17 Rev 1/2001** 29b. Signature and title of certifier

31 Date filed (Month.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835

pm1) 32. Registrar's Signature 29c. License number

285

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 34705 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 November Bernard Edward Cino, 8:31 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, NOV 11. 7. Age (In vrs. last birthdav) **Funeral** 9. Birthplace (State or Foreign Days 1**X** M 2 □ F Months Hours Day, Yea Director 048-26-7254 Yrs 74 Pennsylvania 1935 Usual Residence of Decedent fshow 10a. State 10b. County with the Maryland notified at 10c. City, Town or Location Director 10d. Inside City Limits · 28a-f Maryland Harford Monkton 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be I 10g. Citizen of What Country? Funeral 4207 Sutton Drive 21111 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Armed Forces?

1 □X Yes 2 □ No
If Yes, Give
Year or Dates. 1953–56 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 ₩ Widowed 4 Divorced Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Machinist Air Craft Manufacture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Angelo Cino Scalzo Marv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernadine Nealy/daughter 4207 Sutton Drive Monkton, Maryland 21111 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 11/5/2010 Woodbine, Maryland 21. Signature of Funeral Service Lice Going Home Cremation Service P.O. Box 784 Manuta Beverly L. Heckrotte, P.A. Clarksville, MD 21029 M00957 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition END STAGE RENAL DISEASE Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death ate has been signed by the a page 2 should be detached it Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24a. Was an Were autopsy findings available autopsy prior to completion of cause of death? certificate 2 🗌 No Yes 2 X No 1 Yes or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) ၉ 2 X No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 24 hours after death. Funeral Director: After this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 🗌 Yes 2 🗌 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital ledical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2010 30. Name and ada rspn who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. **JACKIE** JONES, CRNP TIMONIUM, MD 21093

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

NOVEMBER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Thomas Month October Physician/ Η. Countee, Jr. 2°0°10 10:01a^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death
Takoma Park Examiner 4c. County of Death
Montgomery Washington Adventist Hospital If Under 1 Year If Under 24 Hrs.

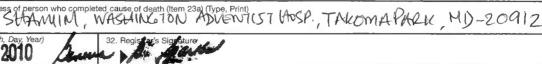
Months Days Hours Min. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 578-52-2372 1 🔀 M 2 🗆 F Months Director DC 08/07/1939 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director ms 23a or 28a-f s must be notified MD Montgomery Silver Spring 1 X Yes 2 No 10f. Zip Code 20910 10e. Street and Numbe 10g. Citizen of What Country? 2100 Washington Avenue 9C Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4X Divorced Completed Black Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5 + Attorney Law other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname, Arrienna C. T 17. Father's Name (First, Middle, Last) and Mental Fishers is marked or Thomas H. Countee Sr. Tucker Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
r 2100 Washington Ave., 10 A, Silver Spring Department of Health ar Important: If item 27 is any injury or other trau Michael E. Countee/ Brother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 ☐ Burial ② Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crem. 11/9/10 Woodbine, MD 22. Name and Address of Facility Cremation Services PO Box 1413, Baltimore, MD 21203 Signature of Fundal Service Lipropota Marshall sentell. Vlaistra 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death RESPIRATORY Immediate Cause (Final FAILURIS Pnysician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner EPSIS Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events EUMON bunial-transit and resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical equires that the death certificate be Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ detached for in the past 12 months? Pregnant at time of death Division of Vital Records, P.O. Part II<mark>. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CEREBROVASCULAR ACCIDENT 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed peen DIABETIC KETOAUDISIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2: autopsy QUADRAPLECOIC performed 1 ☐ Yes 2 ☐ No 1 Yes 2 ANO 25. Was case referred to medical Hospital or Attending Physician: Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined

Registrar

31. Date filed (Month, Day, Year) NOV 0 5 2010

29b. Signature and title of certifier



Medical

29a. Certifie

(Check

only one

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) NOV.01, 2010

			For State	State of M	arylan				nd Mental Hy	giene	01707
			Registrar 1. Decedent's Name (First, Middle, Last)		·	Cer	tificate of E	<i>peatn</i>	2. Date of De	Reg. No.	3. Time of Death
	Physicia		Louis Damico						Month	Day Year 2010	7.204
	Medic Examin		4a. Facility Name (if not institution, give street	et and number)			4b. City, Town, or		Death	4c. County of Dea	ath
			Manor Care Rossv	ille			Ros	sedale	2	Balt	0.
	Funeral Director		5. Social Security Number 6. Sex	7. Ag	je (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	4 Hrs. 8. Date of Bir Min. (Month, Da Januar		rthplace (State or Foreign ountry) aryland
- 4			218-10-7534 Usual Residence of Decedent		0.5				bandar	, 12,1241 11	
	/land f sho	tor	10a. State 10b. County		10c. City	y, Town or Loc					10d. Inside City Limits
	Man 28a- notifie	Director	Md.			Ba1t	imore	_			1X Yes 2 □ No
	ith the		10e. Street and Number				10f. Zip Code	21206		10g. Citizen of What C	ountry?
	ath w	Funeral	4508 Hellwig Road	Was Decedent	Ever in U.S	6. 13. V		21206 spanic Origi	in? (Specify Yes or No-		erican Indian.
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		1 Never Married 2 Married 3 X Widowed 4 Divorced	Armed Forces? 1 Yes 2 If Yes, Give X Year or Dates.		l l	Yes, specify Cuba		in? (Specify Yes or No- Puerto Rican, etc.)	Black, Whi	
2-0	"natu dical	1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No No No No No No No							16b. Kind of Business	s Industry	
121	thin 72 ane. than he Me								Distell	ery	
d 2	led wi Hygie other ent, tl	Be (17. Father's Name (First, Middle, Last)	-		3.13		18. Mother	r's Name (First, Middle,	Maiden Surname)	
<u>lan</u>	d be fil fental rked tic ev	욘	Salvatore Damico					An	toinette Le	eotta	
lany	should and N is ma auma		19a. Informant's Name/Relationship (Type,	Print)		19b. Mailin	g Address (Street a	and Number		er, City or Town, State, Z	
≥,	ind 2 lealth im 27 her tr		Mary Kraemer		DTR.		B Kings	croft		rry Hall, M	
JOF	ge 1 s nt of h : If ite or ot		20a. Method of Disposition 1 ☐ Burial 2 🂢 Cremation 3 ☐ Rer	noval from State		emetery, cren	sition (Name of natory or other plac		Date 1-3-2010	20c. Location - City o	
Ē	nit. Pa artmer ortant injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licer)see			Bayvie			Schimunek		
Ba	permi Depar Impor any ir		Dim Devis			22				ngham, Md,	
	Pnysician/		23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one co Immediate Cause (Final	ause on each lin	e.		r the mode of dying	g, such as c	ardiac or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)	Due to (or as	a consequ	ueno of):	10.00	1	Arrest ulure.	•	
	Lxammer	e.	Sequentially list conditions, b.			Holic	Hear	t fo	ulure.		
	ed	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as	a c usi qu	ience oi);		0			
	xecut n and al-trar	Еха	that initiated events c. resulting in death) Last	Due to (or as	a consequ	uence of):					
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876	tificate ng ph as th		IF FEMALE:				······			T	
9 X	ith cer ittendi or use	Physician/Me	23b. Was decedent pregnant 23c.		2 Feta	al death 3	Ectopic pregnand Other (specify)	У		23d. Date of d	elivery Day Year
œ.	r the a	ıysic	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant a 9 Unknown	at time of c	death 5 ∟	Other (specify)				
P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. On the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	oy Pl	Part II. Other significant conditions contri	outing to death I	but not res	ulting in the u	nderlying cause giv	en in Part I.		obacco use contribute t	
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of \	g Phy er this eral d	e: To	27. Manner of Death	28a. Date of inju	ury	ER/Outpatier 28b. Time of	28c. Injury	/ at		dence 6 Other (Spe how injury occurred	iciry)
ono	ending sath. rr; Afte	ficat	Natural 5 Pending 2 Accident Investigation	(Month, Da	iy, Year)	injury	M work	? Yes 2 🗆	No		
Visi	or Atte fter de irecto n by ti	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inj building, et			eet, factory, office		28f. Location (City or Tox	Street and Number or R wn, State)	ural Route Number,
Ξ	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director, After this certificate has completed filled in by the funeral director, page 2		29a. Certifier 1 Sertifying Physicia	n: To the best =	f my brand	ledge death	occured at the time	date and n	lace and due to the or	suse(s) and manner as e	tated
	e Hos n 24 h e Fun e Fun	Medical		On the basis of e	examination	n and/or invest	igation, in my opinio	n, death occ	curred at the time, date	and place, and due to the	cause(s) and manner stated.
	To the within To the comp		29b. Signature and title of certifier	M.D.		, -3-1	29c. License	number		29d. Date signed (Mon	th, Day, Year)
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			30. Name and address of person who comp			, , , , ,		.] 4	suffer in	Parala.	le MD 2123
	Stat	e	31. Date filed (Month, Day, Year)	32. Registr	as Signat		nds R	er -	204	jacky	110 110 212
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DHMH 17 Rev 7/2009

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	Mary 28a-f otifie	rec	MD	Baltimo	ore	4	Park v	ille '						1 🗆 Yes 2 🔀 No	
	nit. Page 1 and 2 should be filed within 72 hours after death with the Manyland artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at injury or other traumatic event, the Medical Examiner must be notified at e.	Funeral Director	10e Street and Num 9602 Have 9109 Na	en Farm R	Road Unit I)		10f. Zip Coo	e 1234	2112	28	10g. Citizen o		ountry?	
	leath items er m	FE	11. Marital Status		12. Was Decedent E Armed Forces?		13.	Was Decedent of	of Hispan	ic Origin? (Sp	ecify Yes or No- Rican, etc.)	14. F		erican Indian,	
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Baltimore,	permit. Page 1 and Department of Heall Important: If item 2 any injury or other once.	Н	4 ☐ Donation 21. Si valure of Fur	5 Other (Speci	**	land		ation Se 2. Name and Ad				TOLES	C 1111	er, raryrana	
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- 4	hysician/	6.6	Immediate Cause (Final			chr	tnic r	bstr	octive	Duma	mry c	So		
	Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Cond Stage on the Conservation of th												
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Box 68760	ificate ng phy as the	Med	IF FEMALE:											1	
ق ×	h cert tendir r use	an/l	23b. Was decedent in the past 12 r		23c. If yes, outcome 1 Live Birth	of pregnanc 2 Fetal o	leath 3	Ectopic pregr					Date of de		
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27. Manner of Death 28a. Date of injury 28b. Time of injury at work? 28d. Describe ho															
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_	Hospita 24 hours Funeral eted fillec	Medical	(Check 2	☐ Medical Exam		xamination a	nd/or inves	tigation, in my o	pinion, de	eath occurred	at the time, date a	and place, and	due to the	cause(s) and manner stated.	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Robert Paul DeToma November 2010 9:05 A_{\bullet}^{M} Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8207 Bellona Avenue Baltimore Towson 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 🗆 F Months Days Hours Min. 216-56-4219 66 Yrs September 5, 1944 **Director** Massachusetts Usual Residence of Decedent r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at within 72 hours after death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Towson 1 Tyes 2 No 10e. Street and Number 10f. Zip Code Og. Citizen of What Country? United States Funeral 8207 Bellona Avenue 21204 America 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: If Yes, Give 3 - Widowed 4 - Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry oe filed with:
**al Hygiene.
**er than "r (Specify only highest ade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Loyola College 12 Chemistry Professor Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any pirary or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Eleanor Thomas John DeToma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Ronnie B. DeToma/ wife 8207 Bellona Avenue Towson, Maryland 21204 20a. Method of Disposition 20b. Place of Disposition (Name of November 20c. Location - City or Town, State Evans Funeral Air Chapel – Bel Air 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2010 Forest Hill, Maryland 21. Signature Peaceful Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 Service Licen Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician 0/00 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) signed by the attending physician and a betached for use as the burial-transit Exami Uause (Disease of finjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? 4 Pregnant 9 Unknown Pregnant at time of death Month Day Year 2 🗌 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4X Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe this certificate Yes 1 Yes 2 No 2 X N within 24 hours after death.

To the Funeral Director: After this certific.
completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: ဥ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. v one 29b ttle of certifie e and 29c. License number 29d. Date signed (Month, Day, Year) 000 71287 Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 4105, 6701 32. Registr 31. Date filed (Month, Day, Year) ar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ Ам George Ellsworth Engle Sr. 2010 10:15 November Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore White Marsh 10403 Vincent Rd. 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) (Month, Day, **Funeral** Country)
Marvland Hours Months Days Year) 1924 1 🛛 M 2 🗆 F Director 219 12 7547 86 Usual Residence of Decedent 10d. Inside City Limits er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 K No White Marsh Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 21162 USA |10403 Vincent Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 X Yes 2 No II
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 XMarried þ White Maryland 21215-0036 1 ☐ Yes 2 ANO Specify: Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) permit. Page 1 and 2 should be filled within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Steel Mill Chauffeur 8 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna Schmitt ဂ John William Engle traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10403 Vincent Rd. White Marsh, Maryland 21162 Marie Helen Engle (Wife) injury or other Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) Baltimore, Maryland 1 X Burial 2 Cremation 3 Removal from State Holly Hill Mem. Gardens 11/5/2010 4 Donation 5 Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home_P.A. 21. Signature of Funeral Service Licensee ouce. 1407 Old Eastern Avenue Essex Maryland 21221 4 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Retween shock, or heart failure. List only one cause of Onset and Death Immediate Cause (Final disease or condition Physician/ 10 ML TASTATIC Medical resulting in death) Due to (or as a consequence of) **Examiner** RSTRTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and burial-tran Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Month Dav Year in the past 12 months? certificate has been signed by the rector, page 2 should be detached 9 Unknown P.O. I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X No 1 Yes 26. Place of Death (Check only one, Be 25. Was case referred to medical director, examiner? Other: 2 X No 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27 Manner of Death Certificate: injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No M ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) á 4 Homicide determined thin 24 hours after the Funeral Dire

State Registrar

within 2

DHMH 17 Rev 7/2009

Medical

29a. Certifier

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

05 2010

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's agnature

Philase18HIA Ro #314

1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

03355

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ EARECKSON EAN 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Ginger Cove Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex Funeral 1 M 2 F Months Days Hours Min. (Month, Day, Year) Country) Director 577-32-8616 83 une New Jersey Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2X No Annapolis MD Anne Arundel 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21401 USA 8207 River Crescent Drive 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. "natural", or item edical Examiner n 11. Marital Status 14. Race - American Indian Armed Forces? Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working ind Mental Hygiene.
s marked other than "r life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) own home homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental F is marked o ည June Hinman Earl R. Van Leeuwen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $1918\ Buckthorne\ Lane\ Reston,\ VA 20191$ 19a. Informant's Name/Relationship (Type, Print) Page 1 and 2 si ment of Health a Peter Eareckson/son 27 item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Important: If any injury or once. 4 X Donation 5 ☐ Other (Specify) Signature of Funer Service Licensee State Andresmy aboard 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final BREAST WIDEZY CA Physician METASTATIC disease or condition resulting in death) Medical Due to (or as a co sequence of): Examiner Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying as the burial-transit Cause (Disease or liniury and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical or Attending Physician; The law requires that the death certificate be Records, P.O. Box 68760 attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No ō Day Pregnant at time of death 1 Lyes 2 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has page 2 1 ☐ Yes 2 ☐ No Yes Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural injury work? 1 ☐ Yes 2 ☐ No s after death. 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the It within 2 To the It Certifying Nurse Practioner To the best of Shelf-projured at the time date and place, and due to the cause(s) and manner 29b. Signature and title of certifier 29c. License number 21438 41 14

DHMH 17 Rev 7/2009

Registrar

cause of death (Item 23a) (Type, Print)

ACWY3
32. Registrar's Signature

Mame and address of person who complete

31. Date filed (Month, Day, Year)

10-08246

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Diane Ellerbee		State of Maryland / Department of Health an 1- For State Certificate of Death	nd Mental Hygiene 2010 34712
Physicia Medical Examir		1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year October 28, 2010 3. Time of Death 1715 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or 3227 Chesterfield Avenue Baltimore	Location of Death 4c. County of Death
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yea Months Day	15
v any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
ryland a-f shov	ctor	MD 10e. Street and Number 10f. Zip Code	1 1 Pes 2 No
the Mai 3a or 28	Director	3227 Chester Field Ave 21	213 USA
r death with the Maryland or items 23a or 28a-f show any must be notified at once.	uneral		spanic Origin? (Specify Yes or No- n, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
rs after c urai", o	by F	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No	
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) College (1-5 or 5+)	e Agent America
21215-0036 hald be filed within 7 Mental Hygiene. marked other than	Be Co	17. Father's Name (First, Middle, Last) Alton Moses	18.Mother's Name (First, Middle, Maiden Sumame)
MD 21 nd 2 should 1 alth and Mer m 27 is man	ဥ		et and Number or Rural Route Number, City or Town, State, Zip Code
ore, MD ss 1 and 2 sho of Health and If item 27 is her traumati		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cerematory or other place)	metery, Date 20c. Location City or Town, State
		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	ten 11-6-2010 Baltimore, MD
		101553 Valgas	10 PK Pel-Balto MD 21212
Physician /Medical		failure. List only one cause on each line.	Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Cardiovascular Due to (or as a consequence of):	Disease
	iner	Sequentially list conditions, if any, leading to immediate Causa: Linter Underlying Cause b	
ed nsit	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
6 be executed sysician and burial - transit	gical	x UNPENDED ☐ AMENDED 23a,27 per me g909 1	11-10-10 vt
8760 tificate b		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	23d. Date of delivery Ectopic pregnancy Month Day Year
Box 6876(c death certificate the attending phy ed for use as the b	Physician/M	past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (Specify) 9 ☐ Unknown	
that the detached detached	원 문	Part II. Other significant conditions contributing to death but not resulting in the underlying cause g	given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown
ords, F w requires is been sign should be	eted		24a. Was an 24b. Were autopsy findings available
Recor The law i	Completed		autopsy prior to completion of cause of death? 1 Yes 2 ✓ No 1 Yes 2 No
fital Resident The secutificate rector, page	Be	examiner? [Hospital: 4] 1	of Death (Check only one) Other Nursing Home 5 Residence 6 ✓ Other: Scene
ding After	ion: To	27. Manner of Death 28a. Date of Injury (Month, Day, Year) (Month, Day, Year)	ry at Work? 28d. Describe how injury occurred Yes 2 No
Division ospital or Atten hours after death meral Director: y filled in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office b	ouilding, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)
To the Hospital within 24 hours To the Funeral completely filled	Medical Co	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, da cone) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, and manner stated.	
	Ž	29b. Signature and title of certifier 29c. License O.C.N	
	-	30. Name(and address of person who completed cause of death (Item 23a)	
Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	t, Baltimore, MD 21201
Registr	ar	NOV 0 5 2010 Jensey D. Jackel	
DHMH 17 Rev 1/200)1	ORIGINAL	OCANT

Registrar
DHMH 17 Rev 7/2009

State

Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

University

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #29d Per FH G (09 11/05/10 JH State of Maryland / Department of Health and Mental Hygiene 0 1 0 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3,35 PM LILA MAE DINGLE OCTOBER. 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 18 RANDALL AVE BALTIMORE PIKESVILLE 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 9. Birthplace (State or Foreign Months Days Hours Min. OCT 15 1 □ M 2 😿 F Country) Director Yrs. 119-32-2735 80 Usual Residence of Decedent show 10b. County within 72 hours after death with the Maryland Ħ 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified or 28a-f 1 X Yes 2 No BALTIMORE MD PIKESVILLE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 18 RANDALL AVE USA 21208 items 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. ō þ 1 Never Married 2 X Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: BLACK "natural", Specify: Completed 3 Widowed 4 Divorced Year or Dates and Mental Hygiene.
is marked other than "natur raumatic event, the Medical! 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the 12TH DOMES'I'IC PRIVATE FAMILIES permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygic Important: If item 27 is marked other any injury or other traumatic event, ti once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ TOSSIE BENBOW DAISY BENBOW 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GARDENIA MELENDERS/DAUGHTER 18 RANDALL AVE., PIKESVILLE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) KING MEMORIAL PARK 11/04/2010 WINDSOR MILL, MD 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRI. EM. 21. Signature of Funeral Service Licensee 2007-09 EASTERN AVE., BALTIMORE, MD 23a. Part 1. Enter the disease or complications that cau shock, or heart failure was only one cause on each r complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ annan Arte Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical that the death certificate be Records, P.O. Box 68760 as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? jo Month Day Year 5 Other (specify) detached 9 Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires Diabetus Mellitas 1 Yes 2 No 3 Probably 4 Unknown Completed reen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has director, page 2 s autopsy performed? cert ficate Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \square Nursing Home 5 \bowtie Residence 6 \square Other (Specify) 2 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Number Translationer: T. the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
November 03,2010 Mouns RECH 3635-3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Boltimon, Rad 2411 VY B eluston Agu 31. Date filed (Month, Day, Year) **NOV 0 5 2010** 32. Registrar's Signature **State** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Yea **Physician** Edward 1848 M urnie tober 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Min 1 🔀 M 2 🗆 F Director 219-32-3882 <u> Marchl2,1938</u> MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No MD n/a Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? Funeral 1717 E. Oliver St. 21213 USA Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No þ Specify Black Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 6th <u>Laborer(Home Improvement)</u> Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gurnie Edwards Sr. Dorethea Richardson ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Crystal Edwards/ Wife Oliver St. Balto. Md 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Tremation 3 Removal from State Nov.4,2010 4 Donation 5 Other (Specify) GreenMountCrematory Balto.Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. Balto. Md

Do not enter the mode of dying, such as cardiac or respiratory arrest, a) 21213 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician heart failure disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physician and d for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No detached for Month Day 5 Other (specify) the λq Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be de δ 2 No 3 □ Probably 4 □ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 1 ☐ Yes 2 ☐ No 1 TYes 2 No certificate director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence Hospital: 1 ☐ Yes 2 ☑ No 2 - ER/Outpatient 3 □ DOA 1 Inpatient မ 6 Other (Specify) this completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury 28b Time of 28d. Describe how injury occurred Certification: s after death. 5 Pending investigation 1 Natural (Month, Day Year) Injury M 1 🗌 Yes 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide 24 hours 29a. Certifier (check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 - Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) To the within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 241 RES -000 Uctober 31 2010

DHMH 17 Rev 1/2001

State

Registrar

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Valero

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icente

31. Date filed (Month, Pay Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ederickse <u> Boderic</u> 3, 2010 <u>11:</u>30 PM October 0 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 2809 Gillis Falls Road Woodbine Carroll 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Months Days Hours Min. 1 ☑ M 2 ☐ F Director 481-16-5853 94 May 17, 1916 Towa Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location show 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Madical Examilian must be notified at Director 1 ☐ Yes 2 ☐ No Carrol1 Woodbine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2809 Gillis Falls Road 21797 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 【 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No ģ Specify Specify: white 3 Widowed 4 Divorced Year or Dates: 42-45 Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 management analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Conrad William Frederickson Maude Ellen Nelson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ss 1 and 2 sh of Health and fitem 27 is n Mary E. Frederickson/spouse 2809 Gillis Falls Road Woodbine, MD Pages 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ō permit. Pages Department of Important: If it any Injury or or 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Pervice Licensee Roun 1d S. Wards 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CORONARY ARTERY DISEASE **Physician** disease or condition resulting in death) YEARS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to minimize the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed and the attending physician a ned for use as the burial-Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year signed by the a d be detached for 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Ď, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy 1 ☐ Yes 2 ☑ No this certificate 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ∐Yes 2 ₩No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and tale of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11-1-10

State Registrar

NOV 0 5 2010

Ronald E.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Miller 4Culwell Drive MT. AIRY, MD 21771

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Caroline Snyder Fisher November 2010 2:53 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Cente <u>Towson</u> Baltimore 5. Social Security Number 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🔀 F Min. Country) Director Yrs 66 <u>213-48-6313</u> Maryland Usual Residence of Decedent or 28a-f shov 10a. State with the Maryland the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 522 Wilton Road 21286 United States 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force Black, White, etc. 1. Never Married 2 Married ō þ 2 No Yes laryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗷 No Specify "natural", Completed 3 Divorced 4 Divorced Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within it and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Balto., Co. Public 4 Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Elbert Fisher, Jr Zimmerman Page 1 and 2 should ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any injury or other tra Charles Elbert Fisher, III /Brothe: 17600 Sir Galahad Way Ashton, MD 20861 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Nov 05 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Beltsville, Maryland 2010 permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility. Funeral Alternatives MO1885 Ackermor 1/eloes Pastures Drive 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final PULMONALE Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner ひド DOES:+ Complicat Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence or) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month Month Day Year signed by the at d be detached fo Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) 1 🗌 Yes 2 No Other: မ 1 Inpatient 2 X ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) After this filled in by the funeral 27. Mannes of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 24 hours after death. Funeral Director: A 2 🗌 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 To the F only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title d 30. Name and addr s. Charles St

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Day 4:20PM 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Stockmill Road Apt Dikesville Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 X F 242.28.685 Months Hours NC Director Usual Residence of Decedent If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director Baltimore Dikesville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21208 Load 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 \square Never Married 2 \square Married 1 Ves 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 ₩Widowed 4 □ Divorced Year or Dates. 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Brunswick County Schools d Mental Hygiene. marked other than ' life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 1th grade afeteria Be 17. Father's Name First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Stanley Bellamy essle and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau once. Daudster Road HESVILLE MD 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Surset Beach, NC 2010 Pleasant View Cemetery! 4 ☐ Donation 5 ☐ Other (Specify) C. Greene Fundai Services 21. Signature of Funeral Service Licensee Randallstown MD 21133 and 23a. Part 1. Ente√the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart falture. List only one cause on each line Immediate Cause Final Onset and Death Physician/ 0 ementia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner erebral VASCILLAY ACCIDENT Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 🗌 in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pertension 1 Yes 2 No 3 Probably 4 Unknown Completed cate has been s; page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' After this certificate 2 1 No 1 Yes Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No funeral director, 26. Place of Death (Check only one) Be Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 5 Pending
Investigation 1 Natural work? 1 ☐ Yes 2 ☐ No safter death Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de To the Funeral Directo completed filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3510 Novem Ber 2010

State Registrar 5901 north CHaules

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Reba C. Frack 2010 November 4:10 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Lorien Mays Chapel Timonium Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea **Funeral** 9. Birthplace (State or Foreign 1 M 2 4 Months Days Hours Country)
Virginia 98 Yrs Director 229-14-8172 1912 March 26. Usual Residence of Decede or 28a-f show notified at 10b. County with the Maryland 10a, State 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore Manktan 1 🗆 Yes 2 🔽 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 21111 United States P.O. Box 1 and 2 should be filed within 72 hours after death Health and Mental Hygiene. tem 27 is marked other than "natural", or items the raumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 Yes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Completed 3 √2 Widowed 4 □ Divorced Specify White 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Elementary School Teacher Baltimore County Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Dora Hyler David Pleasant Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 24, Monkton, Maryland 21111 Edward Frack, Jr. (Son) Department of Health Important: If item 27 any injury or other to timore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)

Monkton United Methodist Burial 2 Cremation 3 Removal from State ☐ Donation 5 ☐ Other (Specify) Nov. 06,2010 Monkton, Maryland 21 Signature of Funeral Service Licensee

22. Name an Address of Facility

Evans Funeral Chapel & Crematice
16924 York Road Monkton, Mary

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Pfial disease or condition) Evans Funeral Chapel & Cremation Services-Monkton 16924 York Road Monkton, Maryland 21111 Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a conse uence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical ivision of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 After this certificate 2 🗷 No Yes 1 Yes or Attending Physician: 25. Was case referred to dical 26. Place of Death (Check only one) æ xamine . 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify မ 1 Inpatient 2 I ER/Outpatient 3 I DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural Accident Suicide Side Step while 5 Pending 24 hours after death. Funeral Director: A 127/10 1 Yes 2 XV0 4-00PM Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide coation (Street and Number or Rural Route Number City or Town, State) 16712 REMARE PONICTOR, MP 2 28e. P ace of Il jury - At home, farm, street, factory, office building, etc. (Specify) determined AT Home MONICTON Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 A Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item, 23a) (Type, Print) Jule

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registra s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ VLLI065 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3600 Dorshire Court Pasadena Anne Arundel Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Min. 1 M 2 F Months Days Hours Director 217-56-3353 Yrs. 59 March 18 Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoi any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel 1 Yes 2 W No Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3600 Dorshire Court 21122 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Completed 3 X Widowed 4 Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) University of MD Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Medical Center Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Andrew Couslin Helen Ramanauskas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Yirka (cousin) 3600 Dorshire Court, Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Nov 4 Donation 5 Other (Specify) Metro Crematory Inc. 2010 Baltimore, Maryland of Funer 1 Service 1 21. Signatur 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or composhock, or heart failure. List only on cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or sela consequence ory if any, leading to immedicause. Enter Underlying **To the Hospital or Attending Physician:** The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Pregnant at time of death Month Year the the Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown plnods 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed' 2 No ☐ Yes 211 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: မ 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Yes 2 No Accident Investigation within 24 hours after deatl

To the Funeral Director:
completed filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar Vame and address of person

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

pleted cause of death (Item 23a) (Type, Print)

32.

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Physicia	an/						2. Date of Dear	^{Day} 2010	3. Time of Death
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Examir	ier	, , , , , ,	ve street and named)			or Location of Deat ckville	.n	4c. County of De	
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ith th	rall	3313 Sir Thomas	Drive #22		10f. Zip Code	20904		10g. Citizen of What (Country?
ath w	Funeral	11. Marital Status	12. Was Decedent E	over in IIS	3. Was Decedent of		nosify Vos or No	USA	
or its	by F	1 Never Married 2 Married	Armed Forces?		If Yes, specify Cul	oan, Mexican, Puert	to Rican, etc.)	Black, Wh	nerican Indian, iite, etc.
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ould to		19a. Informant's Name/Relationship		105.10	-ille - A.I.I.		Irniger		7. 0
2 shouth and 27 is returned.		Howard Grossenb			33 Enberer			City or Town, State, 2	21p Code) 045
Te, 1 and f Hea item other		20a. Method of Disposition			sposition (Name of	ia refract	- 1	20c. Location - City	
age ento		1 ☐ Burial 2 ☐ Cremation 3 4 🔀 Donation 5 ☐ Other (Spe	Removal from State	cemetery, o	rematory or other pla	ace)			
Dail(IIIIOTE), Maryliand Z I Z I 3-UU30 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Ronal of S			22. Name and Addr	ess of Facility			
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g Phys er this eral dir		27. Manner of Death	28a. Date of injur	y 28b. Time	of 28c, Inju	rv at	lome 5 ☐ Reside 28d. Describe how	nce 6 🗓 Other (Spe w injury occurred	city) Hespice
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r Atte ter de recto	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		y - At home, farm,	street, factory, office			eet and Number or R	ural Route Number,
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To the Hospital or Attending Physical within 24 hours after death. To the Funeral Director: After the completed filled in by the funeral	Medical	(Check 2 Medical Exar	ysicîan: To the best of r miner: On the basis of ex	amination and/or inv	estigation, in my opin	ion, death occurred a	at the time, date and	d place, and due to the	cause(s) and manner stated.
o the rithin 2 o the		only one) 3 Certifying Nu 29b. Signature and title of certifier	rse Practioner: To the b	est of my knowledg	e, death occurred at t	he time, date and pla	ace, and due to the	cause(s) and manner a	s stated.
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		30. Name and address of person who	completed cause of de			R143201		Oct 31, 2	010
		Casey House		, , , , , , ,	. ,	ille. MD	20855		
Stat		31. Date filed (Month, Day, Year)	32. Redistrar	's Signature					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20^{Year}0 11:30a^M N. Gross Juanita Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Piedmont Baltimore Ave If Under 1 Year 8. Date of Birth
(Month, Day, Year) 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2√ F Months Days Hours Min. Country) Yrs Director 44 176-58-5018 65 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 X Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 27 is marked other than "natural", or items 23a of traumatic event, the Medical Examiner must be Funeral 3322 Piedmont Ave 21216 U.S.A. 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 🗶 No If Yes, Give δ Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2X No Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Dept. of Human Resources Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene, 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Dept. State of Maryland 4yrs 12th grade Specialist on Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Men-Important; If item 27 is marke any injury or other traumatic. Richard Fuller Jannie Canndy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3322 Piedmont Ave, Baltimore, Md 21216 <u>Gross I-Husba</u>nd Michael 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Nonation 5 ☐ Other (Specify) Memorial Park 11/8/2010 Woodlawn, Md 22. Name and Address of Facility March F/H West 4300 Wabash Av f Pineral Service Licensee 21. Signature Baltimore, Md 21215 Ave Part 1. Enter the decase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failude. List only one cause on each line. Approximate Interval Between Onset and Death Breast Immediate Cause (Final Physician/ 1 months 12 2 disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury that initiated events Due to or as a consequence of to immediate that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): ŵ resulting in death) Last Physician/Medical Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 ∐ Yes 2 x 9 ☐ Unknown 9 Unknown Division of Vital Records, P.O. signed to detail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician; The law requires 1 ☐ Yes 2 💖 No 3 ☐ Probably 4 ☐ Unknown iis certificate has been si director, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: မ 1 Tes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate Matural Natural 5 Pending injury 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completed filled i Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c. License number D38762 November 2010

State Registrar 32. Regis rar's Signature

Kneun

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bultonon

0

Sharon

Barka

J. McCornack MD

			For State Registrar	State of Maryland	_	artment of F <i>tificate of E</i>			iene 0	0 34723	
	Physicia		1. Decedent's Name (First, Middle, Last) Susan B. Grimmel					2. Date of Death 1000000000000000000000000000000000000		3. Time of Death 250 P M	
	Medic Examin		4a. Facility Name (if not institution, give st Gilchrist Center	reet and number)		4b. City, Town, or Tows	Location of Death		4c. County of I	Death imore	
	Funeral Director		5. Social Security Number 212-70-9733 6. Sex	7. Age (In yrs. la:	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 02-21-1	959	. Birthplace (State or Foreign County)	
_	nd how at	'n	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits	
	Maryla 28a-f s otified	Director	MD Harford		Jarr	ettsville	9			1 ☐ Yes 2X No	
	is 23a or 2	Funeral Di	10e. Street and Number 1605 North Bend Re	1		10f. Zip Code 210)84	1	0g. Citizen of Wha	tt Country?	
9036	s filed within 72 hours after death with the Maryland tal Hygiene. od other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 1 1 □ Never Married 2 🙀 Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	1	Vas Decedent of Hi f Yes, specify Cuba ☐ Yes 2 🗶 No	spanic Origin? (Spe n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White		
Maryland 21215-0036	vithin 72 hor liene. er than "nat the Medica	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Seconday (0-12)		(Give I life. D	lent's Usual Occupa kind of work done of D NOT use retired) cial Anal	luring most of work	ing	16b. Kind of Busin ${f Accounti}$		
land 2	d 2 should be filed within 72 alth and Mental Hygiene. 127 is marked other than "1 raumatic event, the Med	To Be	17. Father's Name (First, Middle, Last) Robert C. Hall				18. Mother's Name	e (First, Middle, M T. Kola	,		
	d 2 should be alth and Mer 27 is marke er traumatic		19a. Informant's Name/Relationship (Type John G. Grimmel	e, Print) (Husband)		ng Address (Street a	and Number or Rura Bend Rd		City or Town, State		
Baltimore,	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State ce	emetery, cren	sition (Name of natory or other place Ville Cem	e)		20c. Location - Cit	y or Town, State	
Balt	permit. Departr Import any inji		21. Signature Fun a Some e densee		22 I	. Name and Addres	ss of Facility Sch MacPhai	imunek F	uneral H	ome of BelAir 21014	
-	nysician/	10.1	23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition	eations that caused the death cause on each line.					st,	Approximate Interval Between Onset and Death	
	Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):						
	ed Isit	Examiner	Sequentially list conditions, if any leading to Immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or es a conseque	side off.						
0	certificate be executed inding physician and use as the burial-transit	edical Exa	that initiated events resulting in death) Last	Due to (or as a conseque	ence of):						
68760	ertificate ding phy se as the	/Med	IF FEMALE:	c. If yes, outcome of pregnan	NCV.						
Box	ath atte for	Physician/M	23b. Was decedent pregrant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 [Ectopic pregnanc Other (specify)	у		23d. Date of Month	f delivery Day Year	
ds, P.O	requires that the death been signed by the atte should be detached for	by	Part II. Other significant conditions cont	ributing to death but not resu	lting in the u	nderlying cause giv	en in Part I.			te to the cause of death?	
ပ္တ	he law te has	Completed						24a. Was an autopsy perform	prior ned? deat	e autopsy findings available r to completion of cause of h? Yes 2 No	
	Physician: The r this certificate fral director, page	Be	25. Was case referred t edical examiner? 1 ☐ Yes 2 ☐ No	spital:		Othe	ace of Death (Checker:	(only one)		1/30/10	
Division of Vital	nding Physician: T ath. :: After this certifica e funeral director, p	icate: To	27. Mann Death 1 Natural 5 Pending 2 Accident Investigation	1 Inpatient 2 E 28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	at	<u>me</u> 5 ∟ Resider 28d. Describe hov	nce 6 Other (S v injury occurred	speciff HOSPICE	
Division	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completed filled in by the funeral	Certificate:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (Stre City or Town,		Rural Route Number,	
	he Hospit in 24 hour he Funera pleted filk	Medical	(Check 2 \(\sumeq\) Medical Examine	ian: To the best of my knowle r: On the basis of examination Practioner: To the best of my	and/or invest	igation, in my opinio	n, death occurred at	the time, date and	place, and due to t	the cause(s) and manner stated.	
	To t with To til		29b. Signature and title of certifier	Alm MD		29c. License	number 6360		d. Date signed (Mi	7	
			30. Name and address of person who con	npleted cause of death (Item 2	23a) (Type, P	Noeru (HARIA STI	aper Bai	Timble	29,2010 ND 21204	
	Stat Registra		31. Days filed (Month, Day, Year)	32. Registrar's Signatu	ire	back	,				

DHMH 17 Rev 7/2009

Edward E	do	gar Green Jr.			
10-08263 UNK UNK	(Please Type or Print in Black Indelible Ink. Ensure All Copies	_	ble.	34724
ONK ONK		State of Maryland / Department of Health and Mental Hyg 1- For State Registrar Certificate of Death	Reg.	2010 No	34124
Physicia Medical Exami	ın/	1. Decedent's Name (First, Middle,Last)	Date of Death Month	Day Year	3. Time of Death 0648 hrs
Medical Exami	ner	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	October 29,	4c. County of Death	
		Sinai Hospital Baltimore		1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8 Months Days Hours Min. Usual Residence of Decedent	11/25	(MM/DD/YYYY) 9. Birth Foreign Cour	11
nd show any	ŗ	10a. State 10b. County 10c. City, Town or Location Baltimore			10d. Inside City Limits 1 Yes 2 No
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f showent, the Medical Examiner must be notified at once.	Director	3800 W. Forest Park Ave #B 21215	10g.	. Citizen of What Count	4
ath with tems 2.	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specific Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Ric		14. Race - America White, etc.	ın Indian, Black,
hours after death "natural", or iter Examiner must	by Fu	3		Specify: B	lacK
hours a		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work during most of working life. DO NOT use retired)		6b. Kind of Business/Inc	lustry
5-0036 led within 72 tygiene. other than "	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Baker		Culina	rv
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name (First, Middle, Last) 18.Mother's Name (Fir	rst, Middle, Mai	iden Sumame)	7
2121: ould be fill Mental I marked ic event,	To Be	Ldwin L. Green, Sr. 19a. Informant's Name/Relationship (Type, rint) 19b. Mailing Address (Street and Number or Rura	I Route Numbe	er, City or Town, State, 2	Zip Code)
nore, MD 2121 sges I and 2 should be fint of Health and Mental it. If Item 27 is marked other traumatic event,		Edwin E. Green, Sr. (Father) 75 W. Washington S 20a. Method of Disposition (Name of cemeter) Disposition (Name of cemeter) Disposition	Street	Annapolis 20c. Location - City or To	MD 21401
MOFe, Pages I a tent of He to If ite		1 Burial 2 Cremation 3 Removal from State crematory or other place)		011	118
Baltimore, permit. Pages I a Department of He Important: If its	ł	Ota Pieratura of Fungasi Consists Lineares	2010 1 uneral	<u> Service</u> Service	, MD
			honal	PIKE (212	Approximate Interval
Physician IV edital		failure. List only one cause on each line. Immediate Cause (Final disease a. Gunshot Wound of Head	spiratory arrest	, shock, or heart	Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a consequence of):			
	Je l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			
T is	xaminer	Colsease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
execu an an	ical	d. UNPENDED AMENDED			
760, cate be physici physici ine buri	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery	
Box 68760, e death certificate b the attending physied for use as the bur	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)		M onth Da	y Year
BO) he death he death hed for	hysi	1 Yes 2 No 9 Unknown 9 Unknown	230 Did tobo	cco use contribute to th	a cause of death?
P.O. es that to general by be detact	ᇫ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	_	2 No 3 Probal	
ords,	oletec		24a. Was an autopsy		psy findings available
Recc The lav	Completed		performe	ed? death? No 1 ✓ Yes	2 No
ital sician:	Be	25. Was case referred to medical examiner? 1 Was 2 No. Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Hospital: 2 Nursing Hospital: 3 DOA Other Nursing Hospital: 3 Nursing Hospital: 3 DOA Other Nursing Hospital: 3 Other		sidence 6 Other:	
	ion: To	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d		v injury occurred	
ivisior or Attend after death Director:	ertification:	Suicide 6 Could not be	f. Location (Street or Town, State	eet and Number or Rura	Route Number, City
Divi lospital or thours afte uneral Dir	O	29a. Certifier	7 Fairview Av	venue, Baltimore, MI	
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due and manner stated.			
F 3 F 3	M	29b. Signature and title of certifier 29c. License number		9d. Date signed (Month	ı, Day, Year)
	-	O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a)		October 29, 2010	
ń		Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			
Sta Registr		31. Date filed (Month, Day, Year) NOV 0 5 20 0 Sequence B. Sparks			
4	_	III V TENTE /			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 31 2010 Year 1:40 P M Saunders Glenner Joyce Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 13105 Jingle Lane Silver Spring Montgomery **Funeral** Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 💁 Hours Oct 25, 192<u>9</u> Director 146-28-1275 81 England Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits or 28a-f Maryland Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 13105 Jingle Lane 20906 United States items ; death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. "natural", or Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates White Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Disability- NonProfit the 5+<u>Administrator</u> Organization Be 17. Father's Name (First, Middle, Last) .. Page 1 and 2 should be filed tment of Health and Mental H tant: If item 27 is marked ot 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ traumatic (Cyrill Frederick Slieth Saunders Lillian Gough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jonathan Saunders Glenner/son 1312 Patrick Drive Mundelein, Illinois 60060 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 and Department of H Date Important: If it any injury or o ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 11/4/2010 Woodbine, Maryland . Sign of e of Funeral Service Lice Going Homes Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Ryhomas stinse M00957 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph, sician/ disease or condition resulting in death) Brain Tumor Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Day 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Parkinson's Disease 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 1 ☐ Yes 2 🔀 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 🗆 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After **X**Natural 5 Pending Accident work 1 🗌 Yes 2 🗌 No Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined edical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 To the I within 2 To the I only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier November 2, 2010 D0037643 30. Name and address of person who completed cause of death (Item 23a) (Type, Prin Thomas M. Hyde, M.D. 4701 Willard Avenue, Suite 233 Chevy Chase, Maryland 20815

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

			1 - For State Registrar		ryland / Depa <i>Cei</i>	artment of F tificate of		h	F	leg. No.	10	34726	
	Physici	an	1. Decedent's Name (First, Middle, Last)						. Date of Dea Month	Day	Year	3. Time of Death	
ether)	/Medic	al	Winford E. Hall 4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Locatio		oct.	28	2010 unty of Death	0745 A M	
	Examin	er		spital		Bal-	1 7	bre		40.000	anty or Death		
	Funeral		Social Security Number		(In yrs. last birthday)	If Under 1 Year	If Und	er 24 Hrs. 8	. Date of Birth) Y)	9. Birth	plece (State or Foreign	
	Director		216-36-3477	M 2□F	70 Yrs.	Months Days	Hours	Min. O	(Month, Day	1940	West	Virginia	
	pu »		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or Lo	antion						10d. Inside City Limits	
	aho	5			· ·	imore						1 ☐ Yes 2 ☑ No	
	286-	Director	MD Baltimor	e	Dait	10f. Zip Code			T .	10a. Citizen	of What Cou		
	3a or	D	10538 Bird River	Road			212	20			USA		
	2 should be filed within 72 hours after death with the Marylend and Mental Hygiene. is marked other than "natural", or items 23s or 28e-f show aumatic event, the Medical Examinational Denotified at	Completed by Funeral	11. Marital Status	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 [X]No	ver in U.S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic (an, Mexic	Origin? (Speci can, Puerto Ri	fy Yes or No- can, etc.)	14.	Race - Ameri Black, White		
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5	n 72 h	lete	15. Decedent's Edu (Specify only highest grad		16a. Dece	ient's Usual Occup kind of work done DO NOT use retired	ation during m	ost of working		16b. Kind o	of Business/Ir	ndustry	
7	withir ene. then	d L	Elementary/Secondary (0-12)	College (1-4or 5+	-}	oncrete		ector		COT	struc	tion	
2	Hygie other	0	17. Father's Name (First, Middle, Last)			onerece		ther's Name (i	First, Middle,				
a	Mental Merital arked o	To B	Winford Ernest Hal	L1				Be	ssie S	mith			
Maryland 2121	shou and M smal		19a. Informant's Name/Relationship (Ty			ng Address (Street				-			
	and 2 eelth n 27		Donna L. Hall/spou	1se		Bird Ri	ver						
altimore,	permit. Peges 1 and 2 should be Deperment of Heelth and Menta Important: If Itam 27 is marked any Injury or other traumatic as <u>pnca.</u>		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☑ Donation 5 ☐ Other (Specify)	lemoval from State	20b. Place of Dispo cemetery, crer	sition (Name of natory or other plac	ce)	Dat	te .	20c. Locati	on - City or T	own, State	
Balti	permit. Depertra Imports any Inju		21. Signature of Funeral Spice Licens ROHALL S.	ade, Dire		Name and Addre	_		655 W.	Balti	imore S	Street	
	100		23a. Part 1 Enter the disease, or complishock, or heart failure. List only or	ications that caused t	he death. Do not ent	1timore, er the mode of dyin			respiratory an	rest,		Approximate Interval Between	
	Physician		Immediete Cause (Final disease or condition			30. 1-1	141	G CF	LIVE	0		Onset and Death	
	/Medical		Immediate Cause (Final disease or condition resulting in death) a. METASTATIC LUNG CANCER Due to (or as a consequence of):										
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	sit ad	Examiner	Sequentially list conditions, if any, hading to immediate cause. Enter Underlying Cause (Disease or injury	Due to lor as a	cons quence of :								
	cate be executed physicien and s the burial-transit	хап	that initiated events resulting in death) Last	Due to (or as a	consequence of):								
58760,	sicien b burit	dical		4									
687		edic		J									
Вох	death certif e attending ed for use as	M/u	230. Was decedent pregnant	3c. If yes, outcome o		Ectopic pregnancy	,			23d	. Date of delin		
о. В	that the death certif ed by the attending detached for use a	Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown	4□Pregnant at t 9□Unknown		Other (specify)					Month	Day Year	
٥.	The law requires that the to be some signed by the bage 2 should be detached.	by Ph	Part II. Other significant conditions con	ntributing to death but	t not resulting in the u	nderlying cause giv	en in Pa	rt I.	23e. Did to	bacco use	contribute to	the cause of death?	
rds	quires in sign								¹ X ¹	′es 2□N	lo 3□Pro	babiy 4 Unknown	
ပ္သ	aw requir is been si 2 should l	Completed							24a. Was		4b. Were aut	opsy findings available	
Ä		E O							autop perfor	med? 2X No	death?	ompletion of cause of 2 No	
ta	ysicien: The is certificate hadirector, page	Bec	25. Was case referred to medical examiner?				26. Pia	ace of Death (
<u> </u>	Physic this ce al dire	ို	1 ☐ Yes 2 No		t 2 ER/Outpatier		4 🗆	Nursing Home				ify)	
Ĕ	ding Ph h. After th funeral	ion:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Dale of Injury (Month, Day	Year) 28b. Time of Injury	Wor	k?		d. Describe h	low injury or	ccurred		
Division of Vital Records,	deal deal ctor: / the	icat	2 Accident investigation 3 Suicide 6 Could not be	28e Place of Injur	ry - At home, farm, str		Yes 2		f Location (9	Street and N	umher or Ru	ral Route Number,	
<u>≥</u>	s after s after al Dire	Certification:	4 Homicide determined	building, etc.	(Specify)	eet, factory, onice			City or Tow	m, State)	3	ar roots rombor,	
	To the Hospital or Attant within 24 hours after deall To the Funeral Director: completely filled in by the	edical	29a. Certifier Certifying Phy (Check only one)	sician: To the best of ner: On the basis of and manner stat	f my knowledge, deat examination and/or in ed.	occurred at the tirvestigation, in my o	me, date opinion, d	and place, an death occurred	d due to the d at the time,	cause(s) and date and pla	d manner as	steted. to the cause(s)	
	To the within To the comp	Me	29b. Signature and title of certifier	0 .		29c. Licens	e numbe	er er		1	igned (Month		
1			> EW/O	C M	D	DI	63	354		10/	28/2	010	
			30. Name and address of person who co	ompleted cause of de	ath (Item 23a) (Type,					4		21010	
			EW COLE ST	HONES	ath (Item 23a) (Type,	ATON 1	TVE	_ BA	LIIM	ORE	MO	alday	
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 5 2010	32. Registral	rs Signature								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 4, 201 0 Harriett Eileen Humphrey 9:46 AΜ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 2258 Monocacy Road Essex Baltimore . Social Security Number If Under 1 Year I If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 M 2XX 11/17/1949 Mary Land Director 213-52-2825 60 Usual Residence of Decedent 10h County 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 28a-f Maryland Baltimore Essex 1 Yes 2 X No 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? Funeral 2258 Monocacy Road 21221 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married XX Married Completed by ☐ Yes 2XX No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) ed other than " Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. 12 Clerk U.S. Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Edward Holtschneider Nellie Virginia Murphy Health and N tem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Humphrey (Husband) 2258 Monocacy Road, Baltimore, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Durial 2 Cremation 3 Removal from State Bayview Crematory, Inc. 11/08/2010 4 ☐ Denation 5 ☐ Other (Specify) Baltimore, Maryland Senature of Juneral Service I censee 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Enter the diseas, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final Pancreatic Physician/ Metastatic disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Date to (or es a consecuence on the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): ding physiciar Physician/Medical or Attending Physician: The law requires that the death certificate be fler death. P.O. Box 68760 as nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 9 Unknown Month Day Year 5 Other (specify) signed by the at d be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed 2 X N Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 힏 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No fler death. 2 Accident
3 Suicide
4 Homicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital within 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Ched) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only d

State Registrar

✓ DHMH 17 Rev 7/2009

29b. Signat

e and title of certifier

31. Date filed (Month, Day, Year)

32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MYO MIN (M.D.) 9(14 Philadelphia Road # 208, Baltimore)

D 45390

November 5th. 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Carolyn Kathleen Hawver Ρ November 2010 6:30 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Center For Hospice Towson If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours (Month, Day, Year) 1 M 2 F 83 Director 220 18 7367 March 28. 1927 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than """ any injury or other than """. 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director Maryland Baltimore Essex 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 956 Kinwat Avenue 21221 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married þ If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify: White Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Secretar Church Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Freda Hetzler John T. Hughes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Henry Hawver Jr. (Husband) 956 Kinwat Avenue Baltimore, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Gardens Of Faith Cemetery 11/8/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A. re of Funeral Service Lies Maryland <u>1407 Old Eastern Avenue Essex</u> Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ BR. ANCER PASI MONTHS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner organization is conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 F FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 X No Pregnant at time of death Month Day Year signed by the a 9 Unknown 9 🔲 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed been a 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s performe After this certificate 2 No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) . Manner Jeath 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Tatural injury 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide after death Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined ε Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F 3 🗆 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

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APWS

STRUCT BALLIMORE MO

and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Pitaine baream Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Robert н. Harvey, Jr. 9:00 PM 2010 Medical November 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 700 Magnolia Road Harford Joppa Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 1 **∑** M 2 □ F May 1925 219-16-4377 85 Maryland Yrs Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🎦 No Maryland Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21085 700 Magnolia Road death \ 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give 2 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: "natural", 3 → Widowed 4 □ Divorced Specify: Completed White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Chief Engineer Merchant Marine Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert H. Harvey Sr. Marie V. Brownsield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert H. Harvey III / Son 700 Magnolia Road, Joppa, Maryland 21085 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Harbor City Cem. 11-8-10 Egg Harbor City, NJ of Funeral Service Licen 22 Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, 21 Sixual Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Justine To Trive Medical Due to (or as a consequence of): Examiner COPD Sequentially list conditions Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Que to for as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed ysician and e burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Year Pregnant at time of death signed by the a 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u></u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has l autopsy performed 90 2 No this certificate 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death

To the Funeral Director: /
completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

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State

Registrar

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David S. Dunn
31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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615 W. MacPhail Road, Bel Air, MD 21014

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d	Medic Examin		4a. Facility Name (if not institution, g				4b. City, Town, o	r Location of	f Death	_	c. County of Death	/
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical Exa	Physician: To the best of aminer: On the basis of extense Practioner: To the	my knowled	dge, death o	ccured at the time	ion, death oc	place, and due to the ca curred at the time, date	ause(s) a	and manner as state e, and due to the ca	ed. ause(s) and manner stated.
	To the within To the comp	2	29b. Signature and title of certifier	11/2	1	w	29c. Licens		4)	29d. D.	ate signed (Month,	
			30. Name and address of person wh	no completed cause of d	eath (Item 2	23a) (Type, Pi		un B	IUD Pa	100	lie ma	21234
(5)	Stat Registra		31. Date filed (Month, Day, Year)	32. Registra	ar's Signatu	- 0				-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1 Month were 201 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Me dicx Age (In vrs. last birthday 8 Date of Birth Birthplace (State or Foreign Country) Funeral 1 ★ M 2 □ F (Month, Day, Year) **Director** 214-56-6285 ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must <u>be notified at.</u> 10b. County 10a. State 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 🔀 Yes 2 🗌 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Park 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ▼ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 【 No Specify. Specify: Black 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 11th grade Shipping & Receiving Clerk Montgomery Ward Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. James Herbert Marjorie T. Purvey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Park Ave, Baltimore, Md 21217 Marjorie T. Purvey-Mother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arbutus <u>Memorial Park 11/8/10</u> Arbutus, Md 22. Name and Address of Facility March F/H West 4300 Wabash Av Sign turn of Funeral Service Licensee Baltimore. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ MURDIUM disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or a consequence of): attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events ut to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death been signed by the should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DISONAEY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 24 hours after death.

Funeral Director: After this certificate has I eted filled in by the funeral director, page 2 s autopsy performe 1 ☐ Yes 2 ☐ No Yes 2 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: မှ 1 Tyes 2 🗷 No Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred ✓ Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 only one 29c. License number address of person who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, Year) 32. Regi trar's Signature State

DHMH 17 Rev 7/2009

Registrar

	•	1 - For Amend Items 2	24a,25 pe	r dr.,	g 909 ; Céi	Timen Tillos Tificate	/201 - 07 L	ealth a Odhb Jeath	and M	lental Hyg R	eg. No.	0	34732
Dia sist		1. Decedent's Name (First, Middle, Las	")							2. Date of Dea Month		Year	3. Time of Death
Physicia /Medic		ISHMEAL ,	HAUGH	TON						10-	16-	2010	4.45 PM
Examin		4a. Facility Name (If not institution, give						Location of	of Death		4c. Coun	ty of Death	
	A.A.		andTou					nore	0411	Y			
Funeral Director		216-42-6678	7. A	ige (In yrs. Ias 68	Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Birth (Month, Day Jan 21,	1942	9. Birthp Cour Pana	lace (State or Foreig try) ama
how		Usual Residence of Decedent 10a. State 10b. County			Town or Lo							1	0d. Inside City Limit
8s-f e	Director	MD		Ва	ltimo	,							Y∰Yes 2□N
23a or 2	ai Dire	3601 O Donnell	Street			10f. Zip 21	224			1	og. Citizen of USA	What Cour	itry?
nial Hygiene. ed other than "natural", or items 23a or 28s-f ehow event, itra Madical Examinar must be motified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 XDivorced	12. Was Deceden Armed Forces 1 X Yes 2 If Yes, Give Year or Dates	i?] No	1	Was Deced f Yes, spec 1 Yes 2				ecify Yes or No- Rican, etc.)	BI	ace - Americ ack, White, ify: bla	etc.
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r than	Completed by	Elementary/Secondary (0-12)	College (1-4or	5+)		ıb dri)			tra	anspor	tation
la p	To Be C	17. Father's Name (First, Middle, Last) William Haughton								e (First, Middle, Haughto		ame)	
= 2 t		19a Informant's Name/Relationship (T Tachaia Haughton		er						; Baltin			
T at to		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☑ Other (Specify,	Removal from State	con	ce of Dispo netery, crer			9)	C	Date	20c. Location	- City or To	wn, State
Department (Important: If any Injury or once.		21. Signature Funeral Service Licens	and the same	ector	22					ite Anat Street;			MD 21201
nysician		23a. Part1. Enter the disease, or comp shook, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each	line.						or respiratory arr			Approximate Interval Between Onset and Death
te has been signed by the attending physician and more considered for use as the burial-transit considered.	ledicai Examiner	Sequentially list conditions of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last	b. HT Due to (or a	s a conseque	nce of):								
by the attending phitached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 ☐ Fetal d	eath 3	Ectopic pre						ate of delive	Day Year
been signed b should be deta	þ	Part II. Other significant conditions co	ntributing to death	but not result	ing in the u	nderlying ca	ius <i>e</i> give	n in Part I.					ne cause of death? ably 4 T Unknov
	Completed					-	-			24a. Was a autops perform	sy	prior to col death?	psy findings availat nptetion of cause o
ertific actor.	Be (25. Was case referred to medical examiner?						26. Place	of Deatl	h (Check only or	10)		
this certific	2	1 162 5 5 140	Hospital: 1 Inpat		R/Outpatier			4 2 190		me 5 Reside			γ)
After fune	tion	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of In (Month, D	lay Year) 2	8b. Time of Injury	M 28	Bc. Injury Work	at :? /es 2 □	1	28d. Describe h	ow injury occi	ntred	
aftar death. Director: A in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Ir building, e	njury - At hom etc. (Specify)	ιθ, farm, str	eet, factory	office			28f. Location (Si City or Town		nber or Rura	I Route Number,
4 hours Funeral	edicai C	29a. Certifier 1 Certifying Phy check only one) 1 Medical Exam	rsician: To the besiner: On the basis and manners	of examinatio	edge, death n and/or in	occurred a	at the tim In my op	e, date an inion, dea	d place, th occurr	and due to the cred at the time, d	ause(s) and r late and place	nanner as s e, and due to	tated. the cause(s)
within 2 To the complei	Me	29b. Signature and title of certifier						number			9d. Date sign		
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1		30. Name and address of person who cosh a bbir 4. CV		/	3a) (Type,	Print)	(0	und	Rac	d Smits	Jo I Ra	n dull	MD211
Sta	ite	31. Date filed (Month, Day, Year) NOV 0 5 2016		trar's Signatur	re						1		1 2 2 7 7

HIS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^{Day} 2010 Month Joseph A. Ignatowski Nov. 1 18:04PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cecil <u>Union Hospital</u> Elkton Social Security Numb 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Birthpiac Country) MD **Funeral** 1 🛛 M 2 🗆 F Months Hours Min. (Month, Day, Year) Director 218-44-6099 63 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director Elkton 1 X Yes 2 ☐ No Cecil MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21921 USA 203 E. Main Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates.Vietnam 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) and 2 should be filed within Technician BGE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 <u>Constantine A. Ignatowski</u> Laura Sieukiewicz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once, 8032 Gray Haven Rd., Dundalk, MD 21222 Jerome Ignatowski-Nephew 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 11-4-10 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory Signature of Funeral Service Licenses 22. Name and Address of Facility Bradley-Ashton Funeral Home Willow Spring Road. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Pnysician/ MOKEC disease or condition 4000 Medical resulting in death) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine The law requires that the death certificate be executed and bunial-tran Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 4 Pregnant 9 Unknown in the past 12 months? Day Yes 2 No the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by disegge Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy After this certificate 1 Yes 2 No Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: Certificate: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident
Suicide within 24 hours after death.

To the Funeral Director: Af Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined the Hospital Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 00055 190 we 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 106 BOW St Vyion tospetal 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 30 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner tonsville, MID Baltimore Social Security Numbe 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Mar 25, Year 935 1 □ M 2 💢 F Months Hours Min. Maryland 215-28-3873 75 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if item 27 is marked other than "nature" any injury or other traumatic average. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2x No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 701 Edmondson Avenue 21228 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔼 No Black, White, etc. 1 Never Married 2 Married þ If Yes Give 1 ☐ Yes 2 🗓 No Specify: Specify: black 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 10 Be unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Timothy Brewer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 611 Central Avenue Towson, MD 21204 Donna Brill/Dept of Aging 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 X Other (Specify) in state Konald S. Walle, State Anatomy Board 655 W. Baltimore Street Director Baltimore. MD 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or impury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) resulting in death) Last ng physician a Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: attendin 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death USE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) o in the past 12 months? Month Year Pregnant at time of death signed by the Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page perform Yes 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) 2/**O**No 1 TYes မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No 1 Natural Accident Investigation s after death Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 24 hours Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Si

31. Date filed (Month, Day, Year,

NOV 0 5 2010

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiere 1. 0

					-	Certificate of			Reg. No.	0 3	34735
	Physic		1. Decedent's Name (First, Middle, La		JON	ES		2. Date of De Month	Day	Year	3. Time of Death 10:40 A
3	/Medi Examir		4a. Fecility Name (If not institution, giv	· · · · · · · · · · · · · · · · · · ·	<u> </u>		4b. City, Town, or L				
			College Man	or Inc	_		Litther	ville	Balti	mor	e County
	Funeral Director		5. Social Security Number 6. S 260-01-3501	ex 7.Age (▼M 2□F	(In yrs. last birt	hday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, De Apr 3,	rth av. Year)		ace (State or Foreign [[] ry)
	show		10a. Stete 10b. County	1	10c. City, Town	or Location				10	d. Inside City Limits
	with the Maryler a or 28a-f show be notified at	ţċ	MD		В	altimore					1√T Yes 2□No
	or 28	J. G	10e. Street and Number			10f. Zip Code			10g. Citizen of V		ry?
	ath w	rai	3931 Cloverhill				1218		US		
21215-0020	within 72 hours atter death with the Marylend ene. than "natural", or Hems 23a or 28a-f show he Medical Evarriner mant be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Wes Decedent Ev Armed Forces? 1 X Yes 2 No If Yes, Give Yeer or Dates:		13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	oecify Yes or No o Rican, etc.)		e - America ek, White, e : White	itc.
5-0	72 hours "natural", adical Exe	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	etion during most of worl	king	16b. Kind of Bu	usiness/Indu	ustry
121	be filed within 72 h. ntal Hygiene. Id other than "natu event, the Medical	E E	Elementary/Secondary (0-12)	College (1-4or 5+))				oduo	ation	
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lan	ould be Mental arked o	To Be	George Noble Jor					es Meldi		,	
Maryland	2 should by and Menta is marked	F	19a. Informant's Name/Relationship (19b.	Mailing Address (Street	and Number or Ru	rel Route Numb	er, City or Town,	Stete, Zip (Code)
	12 # d		Joyce Jones/spo	use	3	931 Cloverh	ill Road	Baltimo	ore, MD	21218	8
Baltimore,			20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 ☒ Donation 5 □ Other (Specification 1)			Disposition (Name of y, crematory or other place	ce)	Date	20c. Location -	City or Tow	vn, State
Balti	permit. Page Department (important: If any injury or once.		21. Signature of Funeral Service Licer Ronal d S	Wate, Direc	ctor	State Anat Baltimore,			. Baltim	ore S	treet
			23a. Pant. Enter the disease, or com shock, or heart feilure. List only	olications thet caused th	ne death. Do n				arrest,		Approximate Interval Between
Mark San Control	Physician /Medical Examiner	ner	Immediate Cause (Final disease or condition resulting in death)	a. Coro			disea			Z	Onset and Death Oyears
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68760,	tificete be executed g physician end as the buriel-transit	Aedicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
P.O. Box	The law requires that the death cert ete has been signed by the ettendin page 2 should be deteched for use a	by Physician/N	Part II. Other significant conditions of	ontributing to death but	not resulting in	the underlying cause giv	en in Part I.				the cause of death? ably 4⊠Unknown
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Division of Vital	IIng Phys I. After this funeral di	lon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Pay)	28b. T	ime of 28c. Injury	4LI Nursing H		idence 6 Other		LIVING
Divisi	or Attendil efter death. Director: A in by the fu	ertifica	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	10/1	/ - At home, far (Specify)	m, street, factory, office	100 12.00	28f. Location (City or To	(Street end Numb wn, State)	er or Rural	Route Number,
_	To the Hospital or Attend within 24 hours effer death To the Funeral Director: completely filled in by the	edical Certification: To	29a. Certifier (Check only one)	ysicien: To the best of r niner: On the basis of en end manner state	xamination and	death occurred et the tire	ne, date and place, pinion, death occu	, and due to the rred at the time,	cause(s) and ma , date and place, a	inner as sta and due to	ated. the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	ارجما	~ J	29c. Licens	e number	4	29d. Date signed	d (Month, E	lay, Year)
			30. Name and address of person who	completed cause of dea	th (Item 23a) (+301	Tow:	son WI	7 2	21204
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's	s Signature	9					· · · · · · · · · · · · · · · · · · ·
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Baltimore Washington Medical Burnie Glen Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Pay, Year 40 1 M 2 🗆 F Months Days Hours 69 Director 214 38 4662 Usual Residence of Decedent 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 🗌 Yes 2 🗶 No MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7848 E. Shore Road 21122 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify. 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Painter Contracting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edward Johnson Bonnie Marie Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau Johnson - wife Linda L. 7848 Shore Rd. Pasadena. 21122 Ε. MD 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 1 🔲 Burial 2 💢 Cremation 3 🔲 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/30/10 Bavview Crematory Baltimore, 21. Signature of Funeral Service Licensee GJ Gonce Funeral Home, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) 9 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 Yes 2 No been signed by the atte should be detached for Pregnant at time of death Month Day Year 9 Unknown Part II<mark>. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Z Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 124 hours after deatn.

Funeral Director: After this certificate has helded filled in by the funeral director, page 2 s autopsy performe 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Man r of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 5 Pending Accident 2 🗆 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe

State Registrar 30. Name and address of person who completed caus

31. Date filed (Month, Day, Year)

32. Registra 's Signature

Fernando Tyrone		otato of that yiana / bop	artmen				gible. 2010	3473
Physicia Medical Examir	ın/	1. Decedent's Name (First, Middle,Last)	•	Or Death		2. Date of Death	Day Year	3. Time of Death 1604 hrs
		Fernando T. Jones 4a. Facility Name (if not institution, give street and number) 2702 Keyworth Avenue Apt 311		4b. City, Town, o Baltimore	r Location of Death		4c. County of Death	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. 214-72-8022 1 M 2 F 52		y) If Under 1 Year Months Day			h (MM/DD/YYYY) 9. Bir / 1957 Co	
eath with the Maryland items 23a or 28a-f show any ast be notified at once.	tor	Usual Residence of Decedent 10a. State	y, Town or I	Baltime	ore			10d. Inside City Limits 1 X Yes 2 No
ith the Mar 23a or 28s notified at	al Director	2702 Keyworth Ave. Apt311			215		Og. Citizen of What Cou	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year or Dates:	U.S. 13	B. Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Amer White, etc. Specify: Bla	ican Indian, Black, ${ t Ck}$
136 hin 72 hours e. than "natur edical Exam	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	duri	redent's Usual Dccupa ng most of working life re Giver			16b. Kind of Business/	
215-00 be filed with ntal Hygien rked other ent, the Me	Be Con	12th Grade 17. Father's Name (First, Middle, Last) Rubin Jones] Ca	ie Giver	18.Mother's Name		_	royeu
MD 21 nd 2 should alth and Me m 27 is ma	ဥ	19a. Informant's Name/Relationship (Type, Print) Tonya Brown(sister)	57	31 Maple	Hill R	d.,Balt	ber, City or Town, State	21239
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medica		1 Burial 2 Cremation 3 Removal from State	Jősép And C	isposition (Name of ce of Brown rematory	F/H 11	Date / 03 / 10		re,MD
Physician		23a. Part I. Enter the disease, or complications that caused the deat	th. Do not er	Joseph H 2140 N.	Fulton such as cardiac o	Jr.Fun Ave., Ba	neral Hom altimore,	e PA MD 21217
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Due to (or as a consequence	cardi					Between Onset and Death
d sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence c. Due to (or as a consequence)						
execul an and al - tra	<u>ica</u>	X UNPENDED AMENSED, PII, 27	per N	ſE g910 12	/22/10 TT	 [
Livision of Vital Records, P.O. Box 68760, within 24 hour after death. To the Hospital or Attenting Physician: The law requires that the death certificate be within 24 hour after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pre 1 Live birth 4 Pregnant at time of d 9 Unknown	egnancy 2	Fetal death 3 Other (Specify)	Ectopic pregna		23d. Date of deliver Month	y Day Year
ires that the signed by the detache	2	Part II. Other significant conditions contributing to death but not Chronic obstructive pulmonar			given in Part I.		bacco use contribute to	
Vital Records, P.C. hysician: The law requires that this certificate has been signed I director, page 2 should be det	Completed	Seizure disorder				24a. Was a autops perform 1 Yes 2	sy prior to o med? death?	utopsy findings available completion of cause of
Livision of Vital Rec vithin 24 hour after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page	To Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No 1 ✓ Yes 2 No 27. Manner of Death 1 X Natural 5 Deadies 28a. Date of Injury (Month, Day, Year)	-,	e of Injury 28c. Inju	ury at Work?	g Home 5 1	Residence 6 Othe	r: Scene
Eivision To the Hospital or Atten within 24 hour after death To the Funeral Director:	ertification:	Accident Investigation Suicide 6 Could not be determined (Specify)	home, farm,		Yes 2 No No building, etc.	28f. Location (S or Town, St		ural Route Number, City
Fo the Hosy within 24 ho Fo the Fun-	Medical C	29a. Certifier (Check only one) 2						
	Σ	29b. Signature and title of certifier		29c. Licen	se number .M.E.		October 27, 201	
park		Name and address of person who concleted cause of death (Itel Russell Alexander MD. Assistant Medical Exal 31. Date filed (Month, Day, Year) 32. Registrar's Signa	miner	111 Penn Street	, Baltimore, M	D 21201		
St: Regist		NOV 0 5 2010	A	back				

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ORIGINAL

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		-	For State Registrar	State of Ma	-	epartmer Certificat				ene g. No. 🥎	016	0:700
			Decedent's Name (First, Middle, Last)			1			2. Date of Death	i	611	3. Time of Death
	Physicia Medio		Shirley L. Kee	eney					October	31,20	10 ^{ear}	1:25A M
_ ;	Examin	er	4a. Facility Name (if not institution, give st	reet and number)			_	ocation of Death		4c. County		
+- ^.	Funeral		Gilchrist 5. Social Security Number 6. Sex	7. Age	(In yrs. last birtho		LOWSO 1 Year	If Under 24 Hrs.	8. Date of Birth			1to. pplace (State or Foreign
	Director] M 2 😾 F	81 Yr	Months	Days	Hours Min.	$\operatorname{June}^{(Month,Day}1)$	929		ryland
	d d		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location						10d. Inside City Limits
	arylan a-f sh fied a	ecto	Md. Balto.		Too. Oity, Town o	Notti	ngham					1 ☐ Yes 2 ☒ No
	or 28 e noti	Dir	10e. Street and Number			10f. Zir			10	ng. Citizen of	What Cou	intry?
	s 23a	Funeral Director	4722 Lavington P	lace			2123	6		USA		
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the M-dical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 ▼ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 💢 I If Yes, Give		13. Was Deced If Yes, spec 1 \(\sum \) Yes	ify Cuban	panic Origin? (Spe , Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)	Bla	ce - Ameri ck, White, :: Wh:	
9	hours natura dical E	Completed	15. Decedent's Edu			ecedent's Usu			1.	16b. Kind of E	Business Ir	ndustry
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2	d with Hygier ther t	BeC	11 th 17. Father's Name (First, Middle, Last)	<u></u>	Sel	f-Emplo		18. Mother's Name				c Store
auc	be file ental H ked o ic eve	일	Calvin G. Willner					Ida V.		arderi Surriam	ie)	
Baltimore, Maryland 21215-0036	should and M is mai		19a. Informant's Name/Relationship (Typ	e, Print)	19b. f	Mailing Address	(Street ar	nd Number or Rura	il Route Number, (City or Town,	State, Zip	Code)
Σ	ind 2 seath		Kathryn L. Whitson	DTR.				n Place				
Jore	ge 1 ant of H		20a. Method of Disposition 1 Burial 2 Cremation 3 F	Removal from State	1	crematory or o	ther place) [20c. Location	•	· -
Itin	artmer ortant injury		4 ♣ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee		Camp Ch	apel C		ry 11-4				.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Ba	Depar Depar Impor any in		Cam Me					lair Roa	himunek d Notti	Funera ngham,	Md,	^m 21236
			23a. Part 1. Enter the disease, or complishock, or heart failure. List only one	cations that caused cause on each line	the death. Do not	enter the mod	e of dying	, such as cardiac o	or respiratory arres	it,		Approximate Interval Between
	nysician/		Immediate Cause (Final disease or condition resulting in death)	Adv	auced		Wall	lia				Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a	a consequence of)							'
		ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a	a consequence of)	:						
	outed nd ransit	Examiner	Cause (Disease or linjury that initiated events								_	
	The law requires that the death certificate be executed rate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	alE	resulting in death) Last	Due to (or as a	a consequence of)	:						
Box 68760	cate by physics the b	ledical		d								
89	ath certific attending for use as	Physician/M	ZSD. Was decedent pregnant	3c. If yes, outcome	of pregnancy 2 Fetal death	3 Fetonic	pregnancy			23d. Da	ate of deli	very
Bô	death he atte ed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4 Pregnant at		5 Other (s)				M	onth	Day Year
P.O.	that the dea led by the a detached t		Part II. Other significant conditions con	tributing to death b	ut not resulting in	the underlying	cause give	en in Part I.	23e. Did tob	acco use con	tribute to	the cause of death?
S, F	ires that signed d be del	d by							1 □ Ye	s 2 🔼 No	3 🗆 Pro	obably 4 🗆 Unknown
ord	v require s been s should	olete							24a. Was an		Were auto	opsy findings available
3ec	The law cate has page 2	Completed							autops perform 1 \sum Yes 2	ned?	death?	ompletion of cause of
Ea 	ysiclan: The is certificate director, pag	Be	25. Was case referred to medical examiner?	ospital:				ce of Death (Checi	k only one)			
Ţ	w 75	2	1 ☐ Yes 2 🔀 No	1 Inpatie	ent 2 ER/Outp		Other	4 L Nursing Ho	ome 5 Resider			m Hospice
o u	nding tth. : After e fune	cate	1 NA Natural 5 Pending 2 Accident Investigation	(Month, Day			work?	res 2 🗆 No	20d. Describe not	w injury occur	160	
Division of Vital Records,	r Atter ter deg rector	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju	ry - At home, fam	n, street, factor	y, office		28f. Location (Str City or Town,		ber or Rura	al Route Number,
Ó	oital o			29								
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director.	Medical	(Check 2 Medical Examin	cian: To the best of er: On the basis of e Practioner: To the	xamination and/or	nvestigation, in	my opinior	n, death occurred a	t the time, date and	place, and de	ue to the c	ause(s) and manner stated.
	To the vithir To the comp	2	29b. Signature and title of certifier				. License	· ·		od. Date signe		
)		1 Short	MI	>	E	>710	540		10/3	1/2	010
			30. Name and address of person who co	-		pe, Print)	1	Λ	-	/		21204
	Sta	te_	31. Date filed (Month, Day, Year)	32. Registra	670) ar' Signature	10 6	llau	i un S	1 100	بالالايا	M	3 81204
	Registr		NOV O	5 2010 ▶	1	M An	ELKA					

Registrar

State

Waltham

woods Ad Purkable MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8313

. Registrar's Signature

Plaja

Yea

NOV 0 4 2010

31. Date filed (Month, Day,

10-0787	1	
Dorothy	Τ.	Kaiti

orothy T. Kaitis	State of Maryland / Department of Health and Mental Hygiene 20 34740 1-For State Registrar Reg. No.									
Physician	1. Decedent's Name (First, Middle,Last)	Date of Death Source A Source Source								
edical Examine	bolothy 1. Kaltis	October 13, 2010								
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea Johns Hopkins Bayview Medical Center Baltimore	th 4c. County of Death								
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24H	Irs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or								
Director	235-24-4432 1 M 2 X F 86 Yrs. Months Days Hours M									
	Usual Residence of Decedent	oct. 20, 1929								
any	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits								
Maryland 28a-f show	Maryland Baltimore	1 X Yes 2 No								
the Maryland or 28a-f sh	10e. Street and Number 10f. Zip Code	10g, Citizen of What Country?								
		USA								
r death with or items 23	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (1 Never Married 2 Married Armed Forces? 11. Marital Status 12. Was Decedent of Hispanic Origin? (14. Was Decedent of Hispanic Origin? (15. Was Decedent of Hispanic Origin? (16. Was Decedent of Hispanic Origin? (17. Was Decedent of Hispanic Origin? (18. Was Decedent of Hispanic Origin? (19. Was Decedent of Hispani									
er dea		_{Specify:} White								
urs afte	lor Dates:	of work done 16b. Kind of Business/Industry								
72 hor	Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker 18. Decedent's Data Occupation (Give kind of during most of working life. DO NOT use of during most of working life. DO NOT use of the during most of the during	etired)								
036 vithin ene.	12 Homemaker	Own Home								
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica		me (First, Middle, Maiden Surname)								
2121 uld be fi Mental I		ca Stamate11os r Rural Route Number, City or Town, State, Zip Code)								
MD 2 12 shou th and N 27 is numatic	-	Bel Air, Maryland 21014								
and 2	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date 20c. Location - City or Town, State								
nor of l	1 X Burial 2 Cremation 3 Removal from State crematory or other place)	-16-2010 Baltimore, Maryland								
Baltimore, MC permit. Pages 1 and 2 s Department of Health at Important: If item 27 injury or other traum	4 Donation 5 Other Specify: Oak Lawn Cemetery 10 21. Signature of Funeral Service Licensee Beth Kehl per DVR Oak Lawn Cemetery 10 22. Name and Address of Facility Bradley-Ashton Fu	10 2010 Daitimore, Maryland								
E Per Per Di	Beth Kehl per DVR 2134 Willow Sprin 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	g Road, Dundalk, MD 21222								
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial failure. List only one cause on each line.	c or respiratory arrest, shock, or heart Approximate Interval Between Onset and								
/Medical Examiner	Immediate Cause (Final disease a Complications of a repaired left hip fracture	Death								
	or condition resulting in death) Due to (or as a consequence of):									
	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):									
-	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):									
be executed ician and urial - trans	□ UNPENDED □ AMENDED #21 per fh,g909,11/05/2010dh									
		23d. Date of delivery								
687 ertific ding p	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic preg	gnancy Month Day Year								
Box 68760	23c. If yes, outcome of pregnancy 23c. If yes, outcome of preg									
hed the de		23e. Did tobacco use contribute to the cause of death?								
P.C rres that signed to be deta	Atherosclerotic cardiovascular disease; pulmonary fibrosis; parkinsons disease	1 Yes 2 No 3 Probably 4 V Unknown								
requir		24a. Was an 24b. Were autopsy findings available prior to completion of cause of								
Reco		performed? 1 Yes 2 V No 1 Yes 2 No								
Division of Vital Records, P.O. Into rattending Physician: The law requires that its after death. al Director: After this certificate has been signed by the funeral director, page 2 should be detacted in the funeral director.	25. Was case referred to medical 26.Place of Death (Che									
Vital I hysician: this certifi I director,	n evaminer?	rsing Home 5 Residence 6 Other:								
ion of tending Pheath. or: After the funeral		28d. Describe how injury occurred Subject fell								
ion ttendi leath. tor:	1 Natural 5 Pending Oct 9, 2010 2200 hrs 1 Yes 2 No									
ivisi lor At after d Direct	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		736 Umbra Street, Baltimore, MD								
To the Hos within 24 h To the Fun completely	293. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.									
To To Com	and manner stated. 29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)								
	M) O.C.M.E.	November 3, 2010								
	30. Name and address of person who completed cause of death (Item 23a)									
	Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore,	MD 21201								
Sta										
Registr	Constant of the second	COME								
DHMH 17 Rev 1/200	Of ORIGINAL									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Vovember 2 2010 /Medical Sounty of Death Facility Name (If not institution, give street and number) Examiner SV 0 KIDA If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct 3 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday **Funeral** Months Hours 1□M 2□F Days 80 Oct 206-22-9957 1930 PA Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medeal Examination. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD Columbia Howard 1 □Yes 2X No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11719 Stonegate Lane 21044 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race · American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) administrative assistant clerical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Olive Edna Cameron Frank William Segner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11719 Stonegate Lane, Columbia, MD 21044 Kirsten K. Emery (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 11-3-10 Sykesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, MD

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. P.O. Box 195 Sykesville, MD 21784 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any leading to in modaticause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a consequence of Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending p as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I., Division or Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has I autopsy perform certificate the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☐ **X**lo 2 ER/Outpatient 3 DOA 1 🔲 Inpatient P 4 Sursing Home 5 ☐ Residence 6 ☐ Other (Specify) this within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 Accident (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number THAM MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

31. Date flied (Month, Day Year)

Rosi

Obrutt

32. Registrar's Signature

		-	For State	State of Ma	aryland /		irtment of H tificate of D		_	- /	010	34742
			Registrar 1. Decedent's Name (First, Middle					Catri	2. Date of De	Reg. No.		3. Time of Death
	Physicia Medic	al	LUTHER		INE	FEL	TER		Month 10		20	
	Examin	er	4a. Facility Name (if not institution,	give street and number)			4b. City, Town, or	Location of Death		4c. C	ounty of Deat	h
	Funeral		5. Social Security Number		e (In yrs. last b	oirthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	th v Year)	9. Birl	hplace (State or Foreign
	Director		216-30-7867 Usual Residence of Decedent	TEM 2LIF	77	Yrs.	Working Bays	Tiours IVIIII	(Month, Da 8-18-	1933	M	aryland
	and show dat	for	10a. State 10b. County		10c. City, To	own or Loc	ation					10d. Inside City Limits
	Mary 28a-f otifie	Director		timore	0	wing	s Mills					1 🗆 Yes 2 🔀 No
	ith the	raiD	10e. Street and Number	- D1			10f. Zip Code	1.7		_	en of What Co	untry?
	eath w	Funeral	403 Bryanston 11. Marital Status	12. Was Decedent E	ver in U.S.	13. V	211 Was Decedent of His	spanic Origin? (Sp	ecify Yes or No-		S . A . . Race - Ame	rican Indian,
36	should be filed within 72 hours after death with the Manyland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show armatic event, the Medical Examiner must be notified at	þ	1 Never Married 2 🔀 Marr	ied Armed Forces? 1 ☐ Yes 2 ☒ If Yes, Give	No		Yes, specify Cubar		Rican, etc.)	Sr	Black, White Decify: T	
Ş	atural	Completed	3 Widowed 4 Divorced	Year or Dates.	1 10		ent's Usual Occupa				of Business	White
215	in 72 h e. nan "n Medi	dmc		st grade completed) College (1-4 or 5	i+)	(Give l life. D	ind of work done d NOT use retired)	uring most of work	ing	Tob. Killo	Of Busiless	industry
2	d with lygien ther th	Be C	11		E	quip	ment Oper			Whit		Curner
Maryland 21215-0036	be filed ental Hy ked oth ic event	70 B	17. Father's Name (First, Middle, L Robert	^{AST)} Klinefelter				18. Mother's Nam	ael All		rname)	
ary	should and Me is mar raumati		19a. Informant's Name/Relationsh			9b. Mailin	g Address (Street a			•	wn, State, Zip	Code)
	permit. Page 1 and 2 should be for Department of Health and Menta Important: If item 27 is marked any injury or other traumatic enonce.		Donna Klinefe	lter Wife			ryanstone	Road O	wings M	ills,	MD 2	1117
Baltimore,	Page 1 a ment of H ant: If ite ury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation	3 Removal from State	ceme	etery, cren	sition (Name of natory or other place	e) i	Date		ation - City or	
Ħ	nit. Pa artmer ortant injury		4 ☐ Donation 5 ☐ Other (S 21. Signatur of Funeral Service L		Mays		el Cemete . Name and Addres					Maryland
Ba	permit. Departr Importa any injt		Stepher	-m Jen	Kens		LINE FUNE					21136
			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that caused only one cause on each line	I the death. D					rest,		Approximate Interval Between
	nysician/ Medical	1	Immediate Cause (Final disease or condition resulting in death)	-a. Acu	TE	H	EMOR	RHAGE	5			Onset and Death
	Examiner		rooding in doding	Due to (or as a	a consequence 4-5 <i>TVC</i>	e of):	ULC	ERS.				
	_	iner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying	b. Due to for as a	1 Consequenc	le Oi).	ULC	Guer	711 B			
	ecuted and transit	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as a			EME	F151	uch			
	icate be executed physician and is the burial-transit	edical E	resulting in death) Last	Due to (or as a	a consequenc	,6 Oij.						
3760	ificate ig phys as the		IS SEMALE:	a								
x 687	th cert tendin or use	Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal de	eath 3 🗌	Ectopic pregnanc	у		23	d. Date of de	
P.O. Box	the ar	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant a 9 Unknown	t time of deat	h 5L	Other (specify)		_		MOHUI	Day Year
P.0	that th	y P	Part II. Other significant condition	ns contributing to death b	ut not resultir	ng in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use	contribute to	the cause of death?
ds,	quires en sign ould be	ted k							1 🗆	Yes 2 🗆	No 3□P	robably 4 Unknown
CO	law rei as be	nple							24a. Was auto	psy }	prior to	topsy findings available completion of cause of
æ	n: The ficate I nr, page	Cor	25. Was case referred to medical				00 PI	(D. II (O)	1 Tyes	2 No	death?	s 2 🗆 No
Vita	ysicial s certi directo	To Be	examiner? 1 Yes 2 No	Hospital:	ent 2 ER/	/Outpatier	Louis	ace of Death (Chece: $4 \square$ Nursing H		dence 6	Other (Spec	ify)
of	ng Phy fter thi ineral o		27. Manner of Death 1 ☐ Natural 5 ☐ Pendir	28a. Date of inju	ry 281	b. Time of injury	28c. Injury work	at at	28d. Describe			.,,,
ö	ttendi death, tor: A the fu	Certificate:	2 Accident Investi	gation not be	unu At hama	farm atm	M 1 🗆	Yes 2 ☐ No	006 1 1 (011	V D	10 to March 1
Division of Vital Records,	al or A s after 1 Direction by		4 Homicide determ	building, etc		, iaiii, siit	set, factory, office		City or To		vurriber or Hu	ral Route Number,
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death, within 124 thours after death, the certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical		Physician: To the best of examiner: On the basis of ex								
	o the l	Me	only one) 3 Certifying 29b. Signature and title of certifier	Nurse Practioner: To the	best of my kn	owledge, o	feath occurred at the 29c. License		ce, and due to the		and manner as signed (Mont	
	FSFO		1 Dec	ul SA	FREH	, M.	A	8808				
	•		30. Name and address of person	who completed cause of d	eath (Item 23	a) (Type, F	rint)			/	126/	
	Sta		Hartan SARCA 31. Date filed (Month, Day, Year)	32 Regi d r	S GA	E.E.n.		Balt	more	, m	17 -	21701
	Registra		NOV	1 5 2010	and a	A	barked					
			3/(11/4/	A FOLO JOSE			-					

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ilylis L Realis		1- For State	Ce	ertificate of		ia ivicitai i i	-	g. No.			
Physicia	ın/	1. Decedent's Name (First, Middle,Last)	Kearns				2. Date of Death	1	3. Time of Death		
ledical Exami	ner	Phyllis Evelyn 4a. Facility Name (if not institution, give street		- 4	b. City. Town. o	r Location of Death	Month August 30,	4c. County of Dea	0752 hrs		
		3537 Millers Lane		Street			Harford				
Funeral Director		5. Social Security Number 6. Sex 1 M 2	If Under 1 Ye		Territor (
any		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Location	on			-	10d. Inside City Limits		
	ь	MD Harford	S	Street					1 Yes 2 No		
n the Maryland 3a or 28a-f sho otilied at once	Director	10e. Street and Number 3537 Miller Road			10f. Zip Code 2115	4	10	g. Citizen of What Co USA	untry?		
er death witl , or items 2 r must be n	Funeral		as Decedent Ever in Umed Forces? Yes 2 X No	If Ye		spanic Origin? (S n, Mexican, Puerto		14. Race - Ame White, etc. Specify: Wh i	erican Indian, Black,		
ours afte	d b	15. Decedent's Education (Specify only high	S:	16a. Decedent	's Usual Occupa	ation (Give kind of		16b. Kind of Busines			
11215-0036 Id be filed within 72 ho fental Hygiene. narked other than "na event, the Medical Ex	ompleted	1	llege (1-4 or 5+)		a Entry			Archit	ect		
115-C e filed v al Hygi ced oth	ျင	17. Father's Name (First, Middle, Last) U	ık			18.Mother's Name	e (First, Middle, M	aiden Surname)	U nk		
b, MD 212 and 2 should b fealth and Meni tem 27 is marl traumatic ever	To B	19a. Informant's Name/Relationship (Type, Pr James M. Kearns – I			,			per, City or Town, Sta	te, Zip Code)		
Baltimore, MD 21215-0036 pemit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 Cremation 3 Rer 4 Donation 5 Other Specify:	noval from State	Place of Disposition crematory or other crematory cremat	er place)		Date /31/2010	Hanover,			
Balti permit. Departr Import		21. Signature of Funeral Service Licensee	, MD 21154								
Physician // Medical		Sa. Part I. Enter the disease, or complication failure. List only one cause on each line.	s that caused the death	n. Do not enter th	e mode of dying	, such as cardiac o	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and		
Examiner			tic (Morphine, Me		toxication				Death		
	_	Sequentially list conditions, if any, leading to immediate Due to	or as a consequence	of):							
	miner	cause. Enter Underlying Cause (Disease or injury that initiated									
ecuted and transit	X	events resulting in death) Last Due to d.									
60, ate be exec hysician ar e burial - t	Medical	UNPENDED	NDED								
ox 68760, eath certificate be exattending physiciar or use as the burial	sician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	If yes, outcome of preg Live birth Pregnant at time of d	2 Feta	al death 3	Ectopic pregna	ancy	23d. Date of delive Month	ny Day Y ear		
Box e death the atte	Physi	1 Yes 2 No 9 Unknown 9	Unknown								
, P.O.	۵	Part II. Other significant conditions contrib Fibromyalgia, Chrohn's Diseas	23e. Did tob	tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown							
rds, require been sig	eted	24a. Was an							24b. Were autopsy findings available		
lecol	Completed							autopsy prior to completion of cause death? 1 Yes 2 ✓ No 1 Yes 2 No			
tal Rectian: The certificate ector, page	BeC	25. Was case referred to medical examiner? Hospital			protein and the second	e of Death (Check					
of Vii ing Physi After this uneral dir	욘	1 Yes 2 No	Date of Injury	ER/Outpatient 28b. Time of In		ury at Work?		Residence 6 🗸 Oth	er: Scene		
Sion of ' Attending Ph r death. ector: After i	tion		OUND: DUND: ug 30, 2010	FOUND: 0745 hrs	1	Yes 2 ✓ No	Unknown				
Divis al or At s after d	Certification:	3 Suicide 6 ✓ Could not be determined	e. Place of Injury - At h		t, factory, office	building, etc.			Rural Route Number, City		
Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical Ce	Suicide 4 Homicide 29a. Certifier (Check only one) 29a Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 3537 Millers Lane, Street, MD Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
To with com	Mec		anner stated.	BAXU	29c. Licen	se number	-	29d. Date signed (N			
		Julor Vetter	Vell	170	O.C	.M.E.		August 31, 201	0		
8		30. Name and address of person who complete Victor Weedn MD JD Assista	ed cause of death (Iter nt Medical Exami		enn Street, I	Baltimore, MD	21201				
St	ate	31. Date filed (Month, Day, Year)	32, Redistrar's Signat		all						
Regist	rar	NOV 0 5 2010	anna	1. 15	**************************************						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 02 1330 Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Glen Burnie Anne Arundel 7212 Crown Road Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗗 F Days Hours Month, Day, Min. 1928 Massachusetts **Director** 81 013-22-5609 ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7212 Crown Road 21060 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Wilbur Pierce Annie Ferris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Kenneth Lang, Jr. / Son 615 Pearl Point Court Millersville, MD 21108 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MD Veterans Cemetery 2010 Crownsville, MD uneral Survice Licensee 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signat M01220 Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ ROKE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ☐ Live Birth 2 ☐ Fetai dea ☐ Pregnant at time of death in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 Ao 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 🗌 Yes Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and title of certifie Day, Year) 29d. Date signed (Month. of death (Item 23a) (Type, Prin 31. Date filed (Month, Day Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 November 10:30 AM Link Alfred Medical George 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore 743 East 37th Street Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth **Funeral** (Month, Day, Year) 9/21/1931 Days Hours 1 X M 2 D F **Director** 215-32-7497 79 Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No <u>Baltimore</u> Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 743 East 37th Street <u> 21218</u> 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 195
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 1X Never Married 2 ☐ Married "natural", or Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: 1955 Year or Dates White permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore City Custodian <u>School System</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Matilda Hudson Paul H. Link, Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Executor of Margaret Elizabeth Smith the Will) Essex, 213 Antietam Road Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other (Specify Entombment Oak Lawn Cemetery 11/8/2010 Baltimore, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Fastern Avenue Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ mok disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Fibrillatio 1200-5 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury or Attending Physician; The law requires that the death certificate be execute attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Myelo pathy Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform After this certificate 2 X 1 🗌 Yes 2 🗌 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be 1 X Yes 2 □ No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XNatural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and tit 29c. License number 29d. Date signed (Month, Day, Year) Attending D1714 NOU 3, 2010 no completed cause of death (Item 23a) (Type, Print) schwartz 21218 MA 3512

DHMH 17 Rev 7/2009

State Registrar NOV 05 2010

31. Date filed (Month,

32. Registrar's Spnature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $\overset{\text{Day}}{2} \underline{0} \underline{10}$ Physician/ Month Milamo 2 12:07. PM MYYM, Nov. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Suburban Hospital Bethesda 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day, Yes New York 1 **x** M 2 □ F Months Days Hours Min Director 164-16-2777 Yrs. 96 Aug. Usual Residence of Decedent or 28a-f show notified at 10b. County within 72 hours after death with the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🏝 No MD North Bethesda Montgomery ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or Funeral 5550 Tuckerman Lane IISA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ò by 1 Never Married 2 X Married If Yes, Give Year or Dates. WWII 1 Yes 2 X No Specify: Specify: White "natural" 3 Divorced 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Dentist Dentistry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked o Alexander Melamed Hanna Katz Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Jeffrey Melamed - Son 67 Forest St., Manchester, MA 01944 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Beth Israel Memorial Park Cemetery 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-05-10 Waltham, MA 21. Signature of Funeral Service Licen 22. Name and Address of Facility Anderson Bryant Funeral Home Bal 4 Common Street, Stoneham, MA 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death iate ause (Final isease or condition resulting in death) Physician/ Escherichia coli bacteremia Medical Due to (or as a consequence of) Examiner Cholecystitis Sequentially list conditions, if any leading to minimize cause. Enter Underlying Cause (Disease or iinjury Examine Die to for as a nonscouerne ch executed and -trans that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical The law requires that the death certificate be IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 L 9 Unknown 9 🗌 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Hypernatremia, Hypokalemia, Aspiration pneumonia, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed Record 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Coronary artery disease, Severe pharyngeal has autopsy performed? Yes 2 No dysphagia 1 🗌 Yes 2 🗆 No Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2 X No ဂ္ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ğ 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 XNatural ision 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours after within 24 hours a

To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 3/C certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature a title of certifier 29c. License number 29d. Date signed (Month, Day, Year,

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State

Registrar

LEVERIVITE

Guevara Nieto, MD

MUY U - ZUIU

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

amed

32. Registrar's Signature

0068405

8600 Old Georgetown Road, Bethesda, MD

November 2, 2010

Reg. No2 0 1 0	3474

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

		Registrar		Cei	uncate of t	Jeani		Reg. No	-010	04141			
Physicia		1. Decedent's Name (First, Middle, Last) Elmer Glenn Morri	.		2. Date of Month		20 ° ro	3. Time of Death 12:05 P M					
/Medic Examin	Medical				4b. City, Town, or	Location of De	ath	4c.	h				
Examini	eı	St. Mary's Hospic			_	Llaway			St. Mar				
Francis		5. Social Security Number 6. Sex	ast birthday)	If Under 1 Year	If Under 24 H	rs. 8. Date of	Rinth	Q Rirl	hplace (State or Foreign				
Funeral		579-52-8765 1¼ M 2□ F 88 Yrs			Months Days	Hours Mi	n. (Month,	Day, Year) , 192	2 Neb	ountry) braska			
Director		Usual Residence of Decedent		Jan 4, 1722 Reblaska									
and w		10a. State 10b. County	10c. City	Town or Lo	cation					10d. Inside City Limits			
f she	ō			0 11						1 ☐ Yes 2 ☑ No			
28a-	Director	MD St. Mary	/'S	Calla				140	log. Citizen of What Country?				
Vith T		10e. Street and Number			10f. Zip Code	20600		Tog. Citi					
ath v	ra	44916 Widgeon Pi				20620		1	USA				
tems rer	Funeral	11. Marital Status	2. Was Decedent Ever in U.S Armed Forces?	3. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? an, Mexican, Pu	(Specify Yes or erto Rican, etc.)	No-	14. Race - American Indian, Black, White, etc.				
or i	by F	1 Never Married 2 Married	1 X Yes 2 □ No If Yes, Give		1 □Yes 21X No	Specify:			Specify: White				
ural'	g D	3 Widowed 4 Divorced	Year or Dates: '40-						Constitution with the constitution of the cons				
72 h	Completed	15. Decedent's Educa (Specify only highest grade		(Give	dent's Usual Occup kind of work done	during most of w	vorking	16b. Ki	nd of Business/	Industry			
han he.	ш	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired								
led v lygie her t		12	0	1e	ns grinde		/F: 14: /		tical c	ompany			
be find he find he dot	Be	17. Father's Name (First, Middle, Last)					lame (First, Mid		Surname)				
ould marke	ပ္	Guy Lester Mor	ris			E 3	fie Cul	ver					
2 sh and Is m		19a. Informant's Name/Relationship (Typ	e. Print)	19b. Mailir	ng Address (Street	and Number or	Rural Route Nu	mber, Cify o	r Town, State, 2	Zip Code)			
and ealth m 27 mer to		Helen Morris/spou			6 Widgeo	n Place							
of H		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	CC	ace of Dispo metery, crer	sition (Name of natory or other plac	ce)	Date	20c. Lo	cation - City or	Town, State			
Pag ment ant: I		4∑ Donation 5 ☐ Other (Specify)	11			1							
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examitrer must be redified at once.		21. Signature of Funeral Service Licenses Ronal d S	ade, Director	32	Name and Addre	ss of Facility	rd 655	W. Bal	ltimore	Street			
82 = 89		12mm ///	JUL BURGE		altimore,	-		n. bul	LOIMOIO	501000			
		23a. Part I. Enter the disease, or complic	ations that caused the death					y arrest,		Approximate Interval Between			
Physician		shock, or heart failure. List only one Immediate Cause (Final		MER	'C DIS	SACE	2			Onset and Death			
/Medical		Immediate Cause (Final disease or condition resulting in death) a. ALZHEIMER'S DISEASE											
Examiner		Due to (or as a consequence of):											
	er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):											
uted Insit	min	cause. Enter Underlying Cause (Disease or injury that initiated events c.											
exect n and al-tra	Examiner	resulting in death) Last	Due to (or as a consequ	ence of):									
th certificate be executed ending physician and ruse as the burial-transit													
ficate phy s the	an/Medical	d.											
certi oding se a	W/	IF FEMALE:	c. If yes, outcome of pregnar	ncv					23d. Date of de	livon			
eath atter for u	iar	in the past 12 months?	death 3[☐ Ectopic pregnanc ☐ Other (specify) _	У		_ '	Month					
he d the	Physicia	1 □Yes 2 □No 9 □ Unknown	4 ☐ Pregnant at time of de 9 ☐ Unknown										
that t	띰	Part II. Other significant conditions cont	ributing to death but not resu	nderlying cause giv	en in Part I.	23e. D	23e. Did tobacco use contribute to the cause of						
sign sign d be	by	•	,···g g··		1	∐Yes 2Ì	X No 3□P	Probably 4 Unknown					
requ	Completed						-			,			
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clan: ertifik ctor,	Be	25. Was case referred to medical examiner?				26. Place of D	eath (Check or	ly one)					
hysic his c	၉	1 ☐ Yes 2 ☐ No	ospital: 1 Inpatient 2 I	ER/Outpatier	nt 3 □ DOA Oth	er: 4 🗆 Nursin	g Home 5 ☐ F	esidence	6 Other (Spe	ecity) HOSPICE			
ng P fter t nera	ü	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time o Injury	f 28c. Injur Wor	y at k?	28d. Descri	be how injur	y occurred				
eath.	atic	2 ☐ Accident investigation				Yes 2 □ No							
er de recte by t	ti	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify	me, farm, str	eet, factory, office			n (Street an Town, State		ural Route Number,			
tal on its aft all Di	Certification:												
ospi hou uner	cal	29a. Certifier (Check only 2 Medical Examin	ician: To the best of my know er: On the basis of examinat	wledge, deat	h occurred at the ti	me, date and pl	ace, and due to	the cause(s	and manner a	is stated.			
To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for u	Medical	one)	and manner stated.										
To t	Σ	29b. Signature and title of certifier	P		29c. Licens	e number	-/ 2	29d. Da	te signed (Mon	th, Day, Year)			
) / while	Du		100	00315	65	aci	0 BEK	20,0010			
		290. Signature into the original property of the interview of the intervie											
			CK MD 2096	45 GR	EATWIL	5 KOMP	LEXING	1000	PITTER,	1417 2065 >			
Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signat	back	,	7							

1 Tes 2 No

Dav Year 23e. Did tobacco use contribute to the cause of death? 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 1 ☐ Yes 2 X No 28f. Location (Street and Number or Rural Route Number, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated United Tentifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month. Day, Year) 2016 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRINCE PHILIP DRIVE #327 MD BANNEN 18115 OLNEY 20832 31. Date filed (Month, Day, Year) 2. Registrar's Signature State NOV 05 Registrar J DHMH 17 Rev 7/2009 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ - 404 M 2016 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ONTGOMER If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 💆 F Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, ပ 19a. Informant's Name/Relationship (Type, Print) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) ____ in the past 12 months? Day Pregnant at time of death Year s been signed by the should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? SENILE DEMENTIA 1 Yes 2 No 3 Probably 4 Unknown INTESTINAL VASCULAR ECTASIA WITH 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 BLEED 2 🗌 No 1 Yes 25. Was case referred to medical examiner? Hospital: 흔 2 XNo Ot 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 27. Manner of Death Certificate: 28b. Time of 28c. Inju 1 Natural 5 Pending

or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been completed filled in by

28a. Date of injury (Month, Day, Year)

lace of Death (Check only one)										
her: 4 Nursing I	Home 5 🕱 Residence 6 □ Other (Specify)									
ry at rk?] Yes 2 ☐ No	28d. Describe how injury occurred									

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) as stated.

	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
only one) 3 Certifying Nurse Practioner: To the best of my knowledge	, death occurred at the time, date and place, and due	to the cause(s) and manner as stated.								
o. Signature and title of certifier	29c. License number	29d. Date signed (Monty, Day, Year)								

Investigation

determined

6 Could not be

f person who completed cause of death (Item 23a) (Type, Print)

7500 GAEGNWAY CTR DR GREENBELT, MD 20770

State Registrar Accident

Suicide

4 Homicide

To the Hospital

10-08306

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

INK UNK		Since State	tate of Maryla		artment o <i>rtificate o</i> :			Menta	al Hy	giene	2	201	0	34	750
Physicia		Registrar 1 Decedent's Name (First, Midd	lie,Last)		rincate o	Deau			2	. Date of De				3. Time of	Death
Medical Examiner		JoVanna Nico			Mitchell				Month Day Year October 31, 2010			`	0339	hrs	
		4a. Facility Name (if not institution University Hospital	on, give street and nu	ımber)	4b. City, Town, or Location of Death Baltimore			Death		4c.	County o	f Death			
Funeral		5. Social Security Number	7. Age (In yrs.	last birthday)		r 1 Year	If Under		8. Date of B	irth (MM/t	th(MM/DD/YYYY) 9. Bir			te or	
Director		165-72-6544	1 M 2 X F	20	O Yrs	Months s.	Days	Hours	Min.	03	23	23 90 Fore			PA
any	F	Usual Residence of Decedent 10a. State 10b. County		10c, City	, Town or Local	tion								10d. Inside	e City Limits
	۰	MD	NA	ĺ		ltimore						1 Yes 2 No			
Maryland 28a-f show d at once,	ecto	10e. Street and Number				10f. Zip Code						en of Wh	at Coun	try?	
ith the Maryland 23a or 28a-f sho notified at once.	ä	2769 West No	orth Ave				2121	.6				U.S	. A .		
ith with	Funeral Director	11. Mantal Status 1 X Never Mamed 2 M		cedent Ever in U orces?		as Deceder Yes, specify				cify Yes or Nican, etc.)	0-	14. Race White		an Indian,	Black,
her des			1 Yes	2 X No	1	Yes 2	v No	specify:				Specify:	D 1	م ماء	
ours a	d by	15. Decedent's Education (Spe	or Dates: ecify only highest grad	de completed)	16a. Deceder	nt's Usuai (ind of Bus		ack ndustry	
36 in 72 h nan "n lical E	plete	Elementary/Secondary (0-12)		I-4 or 5+)	ľ		Ü	JO NOT U	se reure	(د		. 5		7.	
d with ygiene ther the	Completed	11th grade 17. Father's Name (First, Middle	na , Last)		<u> </u>	ashi		3.Mother's	Name (F	irst, Middle,		(CDO)	naı	u·s	
21215-0036 uld be filed within 72 hours after death with the Maryland Mental Hyggene. marked other than "natural", or items 23a or 28a-f she event, the Medical Examiner must be notified at once	Be	Anthony Hami					_T $ $	rinr	na N	litch	ell				
	٩	19a. Informant's Name/Relations	ship (Type, Print)				(Street	and Numb	er or Ru	ral Route Nu	mber, Cit				016
구 전투 표 등		Trinna Izzar 20a. Method of Disposition	a-motner		Place of Dispos					Ba.				Cl ZI	
Baltimore, permit. Pages 1 at Department of He Important. If ite		1 Burial 2 X Cremation		om State	crematory or ot			·		7 (00					
Baltimore permit. Pages 1 Department of F Important: If i		4 Donation 5 Other Specify: IVV Hill 21/ Signature of Funeral Service Licensee / 22. Name and Addr						11/11/2010 Philadelphia, PA Address of Facility ice Funeral Chapel, Inc. 19150							
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart								hial	9 <u>15</u> 0				
Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause	on each line.					uch as car	diac or r	espiratory ar	rest, sho	ck, or hea	rt	Between	Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Gunshot Wounds (2) of the Torso and Arm Due to (or as a consequence of):											eath		
		Sequentially list conditions, b													
	jne	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause C.													
pg isit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):													
50, te be executed ysician and burial - transit	edical	UNPENDED	d AMENDED										'		
760, Teate be physici		IF FEMALE: 23b. Was decedent pregnant in t	-	outcome of preg			- (-	7	-1-			. Date of			
Box 6876(c death certificate the attending phy ed for use as the b	Physician/N	past 12 months?	4 Pregn	oirth ant at time of de		etal death ther (Spec	3 <u> </u> f(v)	Ectopic p	regnand	:y		Month	Đ	ay	Year
BO ne deat the at	hys	1 Yes 2 No 9 ✔ Un	3 _ Onkire												
Sion of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be reath. ector: After this certificate has been signed by the attending physicible the fineral director, page 2 should be detached for use as the buril.	2	Part II. Other significant condi	tions contributing to	o death but not r	resulting in the i	underlying	cause giv	en in Part	l.		_			he cause o	
ords, P w requires the second of the second	eted							_	_	24a. Was					gs available
Recol The law icate has	Completed	-								auto perfo	ormed?	de	eath?	ompletion o	
tal Rection: The certificate ector, page	Be	25. Was case referred to medica				2	6.Place o	of Death (C	heck on			1	V 10.		
of Vital ling Physician: After this certif	P P	examiner? 1 Yes 2 No		Inpatient 2 🗸	-					Home 5	Resider		Other:		
Division of Vital Records, tal or Attending Physician: The law requir rs at er ceath. al Lirector: After this certificate has been sted in by the funeral director, page 2 should the	ë E	27. Manner of Death 1 Natural 5 Pen	28a. Date FOUND	of Injury , Day,Year)	28b. Time of I FOUND:	Injury 2		at Work? s 2 ✔ N	9	8d. Describe ubject sho		ry occurre	edi		
isio r Atter er cal irector	ficat	2 Accident Inve	stigation Oct 31,	2010 e of Injury - At h	0250 hrs ome, farm, stre	et, factory,	5-71			8f. Location (Street ar	nd Numbe	r or Rur	at Route N	umber, City
Div	Certification:	Suicide 6 Could not be 4 Homicide Homicide Could not be determined (Specify) Porch													
Division To the Hospital or Attendi within 24 hours at er ceath. To the Funeral Director: completely filled in by the fi			hysician: To the besiminer:On the basis												
To To com	Medical	29b. Signature and title of certific	and manner s				License							th, Day, Yea	ar)
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	ł	30. Name and address of persor		-							J				
		Patricia Aronica-Polla 31. Date filed (Month, Day, ¥ear)		ant Medical				et, Balt	more,	MD 2120)1				
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DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1819a Per PHY &FH G910 12/22/10 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 30 Rosalie Lorrain Morrow Rosalie Morrow October 20108:45 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Harford Lorien Riverside Belcamo Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth s. Date of Birth (Month, Day, Year) Sep. 6, 1919 1 □ M 2 □¥ Days New Jersey Director 91 152-05-5871 Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🏝 No Maryland | Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 520 Silverside Road 21040 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian. Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Cost Accountant Telephone Manufacturer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John (unk) Kackos Rose Elizabeth Lotsko 19a. Informant's Name/Relationship (Type, Print)

John J. Morrow

John T. Morrow / Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 520 Silverside Road, Edgewood, MD 21040 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-5-10 Holy Cross Cemetery North Arlington, NJ 21. Signature of Funeral Service Licensees

**Tathler a. S 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disean DIMONS disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or illigary that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Uhruhu 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy after death.

Director: After this certificate ! 2 **8** No 1 Yes 22 No Yes To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 🔊 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🛭 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1. Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1/10 D29227 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 West Mar PhatiRe RelAir M ZINLY BYOIKI 31. Date filed (Month, Day Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month EVS 26 600 P Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death 2107 Haverbrook Drive Fallston Harford If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 62 yrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD 1 M 2 □ F 2/Y87 P948 Director 218-46-5788 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MDHarford Fallston 1 ☐ Yes 2 🏝 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 2107 Haverbrook Drive 21047 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 🖾 Yes 2 🗌 No Black, White, etc. 1 Never Married 2 Married by 21215-0036 White 1 ☐ Yes 2 🖾 No Specify: If Yes. Give 3 Divorced 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Millwright Bethelehem Steel Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. John Meyers Helen Vogel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Meyers- Spouse 2107 Haverbrook Drive Fallston, MD 21047 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart of Jesus 10/30/2010 Dundalk, MD Donation 5 Other (Specify) Signature of Tape al Service Lice 22. Name and Address of Facility Schimunek Funeral Home of Bel Air Rd. Bel Air, MD 21014 610 W. MacPhai 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ung cancer week Medical Due to (or consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) that the death certificate be executed Cause (Disease or impury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of) After this certificate has been signed by the attending physician if tuneral director, page 2 should be detached for use as the burial Physician/Medical I Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director: After this certificate has been considered. praestive 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation the 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie (Item 23a) (Type, Print)
Hapkins Hospital, 720 Rutland Ave, Baiti 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Regist State 5 Registrar

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ryant Millard M		State of Maryland / Department of Certificate of Ce		iygiene	2010	34753
DI: -:-:		Registrar 1. Decedent's Name (First, Middle,Last)	Death	Reg 2. Date of Death	. No.	3. Time of Death
Physicia Iedical Exami		Bryant M. Mallory, Jr.			Day Year	0545 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
		7939 Wise Avenue	Dundalk		Baltimore Cou	nty
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs	s. 8. Date of Birth	(MM/DD/YYYY) 9. Birt	
Director		$213-70-4768$ $ _{1 \times M}$ $_{2} \cap _{F}$ 52	rs. Months Days Hours Min	2-1-19	958 Foreig	n intry) MD
		Usual Residence of Decedent				
/ any		10a. State 10b. County 10c. City, Town or Loc	ation			10d. Inside City Limits
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th the Maryland 23a or 28a-f sho notified at once.		7939 Wise Ave.	21222		USA	
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36 bin 72 than	g		struction Work	ker [Home Impr	ovement
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215 215 se file set a ked o	Be (Bryant M. Mallory, Sr.	Marle	ne Crabl	0	
21 ould b d Mer s mar	흔	19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ng Address (Street and Number or	Rural Route Numb	er, City or Town, State	Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh injury or other traumantic event, the Medical Examiner must be notified at once			7 Willow Ave.,			
re, lan f Hea		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State crematory or 3	osition (Name of cemetery, other place)	Date	20c. Location - City or	Fown, State
Page:		4 Donation 5 Other Specify:	other place) Lc Crematory 1	1-3-10	Glen Burn	ie, MD
Baltimore, permit. Pages 1 at Department of He Important: If ite			. Name and Address of Facility Bra	adley-As	shton Fun	eral Home
0 2553		Tithether !	2134 Willow Sp	ring Roa	ad, 21222	
Physician Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.		or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
Examiner	Ĭ	Immediate Cause (Final disease or condition resulting in death) a. Methadone nad ethan	ol intoxication			Death
		or condition resulting in death) Due to (or as a consequence of):				
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tox 68760, eath certificate be eath certificate be eatending physicia for use as the buria	Med	IF FEMALE: AMENDED 23a, 27, 28a-f, per 23c. If yes, outcome of pregnancy	ME g909 11/18/1	0 TT	23d. Date of delivery	
587 artifica ling p	an/I	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregna	ancy		ay Year
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D. B. It the de by the	Physician/Med	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e, Did toba	acco use contribute to	he cause of death?
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physicin phetely filled in by the funeral director, page 2 should be detached for use as the buring	ρ		, , , , , , , , , , , , , , , , , , ,	1 Yes		ably 4 🗸 Unknown
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ath.	Ę	Pending F4 10/20/10 F4 5.4	1 Yes 2 No	unk		
/iSi r Att rer de irecto n by t	fica	2 Accident Investigation Rd 10/30/10 Fd 3.2 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, str		28f. Location (Str	reet and Number of Ruite)	al Route Number, City
ital o	Certification:	4 Homicide determined (Specify) found at home	٤	Dundalk	, MD WIS	e Ave
Hosp 24 ho Fune etely f		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ				
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical	one) 2 Medical Examiner: On the basis of examination and/or investige and manner stated.	ation, in my opinion, death occurred a	at the time, date ar	nd place, and due to the	e cause(s)
	Σ	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mor	
		rote Un- Toller	O.C.M.E.		October 30, 2010	
		30. Name and address of person who completed cause of death (Item 23a)	111 Donn Chast Dalit	n MD 04004		
		Patricia Aronica-Pollak MD. Assistant Medical Examiner	111 Penn Street, Baltimor	ie, IVID 21201		
Si Regis	tate trar	31. Date filed (Month, Day 00 0 5 20 10 Registra's Signature	of arked			

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician Year 1050 November Incresc 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Director 173-22-7572 78 19,1931 Dec. Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 21 No Director MD Worcester Pocomoke City 10e. Street and Number 10g. Citizen of What Country? 10f. Zip-Code Funeral 1239 Buck Harbor Road 21851 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. I and 2 should be filed within 72 hours after leath and Mental Hygiene. on 27 is marked other than "natural", or ite 1 ☐ Never Married 21 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 by b 1 ☐ Yes 2 🙀 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Howard J. Spratt <u>Marion Rowan</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any injury or other tra Thomas D. Martin Husband 1239 Buck Harbor Road, Pocomoke City, MD 21851 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/6/10 Carroll Cremation Hampstead, MD 21. Signal re f Juneral S-ivice Licensee 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician Ventricular tachicaldic /Medical Due to (or as a consequence of k-Examiner Atrial Abrillation Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Examine Day to for as a consequence of death certificate be executed use as the burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760, physician Physician/Medical attending IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Day Year 5 Other (specify) been signed by the at should be detached t P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has 2 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{\text{Pesidence}} \) 1 Inpatient 2 ER/Outpatient 3 DOA မ 6 Other (Specify) 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: i or Attending P after death. Director: After ti 5 Pending investigation 1 Yes 2 No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral D 29a. Certifier (check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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DHMH 17 Rev 1/2001

State Registrar Res - 000

MDPLO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3. Registrar's Signature

Annukka

31. Date filed (Month, Day, Year)

11/2/10

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 💪 U For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month November .2010 8:30A Lillian Josephine Novak Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Balto. Stella Maris Hospice Timonium If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F Months Days Hours Min 28 Maryland Yrs **Director** 212-22-8971 F<u>ebruary</u> Usual Residence of Decedent 28a-f show and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f shor raumatic event, the Medical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No N/A Baltimore City Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 11 Walnut Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates Specify Completed 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Waitress Food Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lillian Josephine Crowley John Tobias Lutz injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. 1526 Briarhill Estates BelAir, Md. 21015 Wayne R. Novak Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 11-9-2010 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Parkville, Md. 22. Name and Address of Facility Schimunek Funeral Home 21. Signature of Fineral Service 9705 Beliar Road Nottingham, Md, 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition SEPSIS Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ned by the atter in the past 12 months?
1 ☐ Yes 2 🛣 No
9 ☐ Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be def Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? certificate 1 ☐ Yes 2 ☐ No Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 X No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending thin 24 hours after death.

the Funeral Director: Af
empleted filled in by the fu 1 🗌 Yes 2 \square No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🛣 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year, of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address JONES CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year, 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

NOVEMBER

LILLIAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Ö4, GREGORTA ONNA аМ 2010 7:40 November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist Hospice Center 8. Date of Birth (Month, Day, Yea wher 22 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Days 1 - M 2 X Months 581-60-2204 **Director** Puerto Rico 73 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Anne Arundel Pasadena 1 Yes 2X No Maryland 10f. Zip Code 21122 10e. Street and Number 2895 Gladnor Road 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 X Yes 2 □ No Specify: Puerto Rican If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. other than " College (1-4 or 5+) Elementary/Seconday (0-12) Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Maria Torres nd Mental F marked of Manuel Alvarez ၉ other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2895 Gladnor Road, Pasadena, Maryland 21122 and N 19a. Informant's Name/Relationship (Type, Print) . Page 1 and 2 sl tment of Health a tant: If item 27 i Gilbert Onna (Husband) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If it any injury or o 1 X Buria! 2 Cremation 3 Removal from State Cem. Nubvb Municipal Nov. 11,2010 Arecibo Puerto Rico 4 Donation 5 Other (Specify) 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. Signature of Funeral Service Licenses 3204 Mountain Road, Pasadena, Maryland 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Pneumonia elle c Medical Due to (or as a consequence of Examiner Debiuit mouths Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy for in the past 12 months?
1 Yes 2 Who Year Pregnant at time of death 5 Other (specify) Month Day the be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 YOther (Specify) HSSPICY ၉ 1 Inpatient 2 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 🗌 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🕊 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated D0070635 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N charles St Patrel Suite 4105 Baltmore, MD 21204 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar 0HMH 17 Rev 7/2009

ORIGINAL

3:42 р.ш. NOVEMBER 4, 2010

JAMES OLIVER

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		-	For State Registrar	State of M	aryland		artment of I tificate of I		мепта ну	giene Reg. No2	010	34757
	Physicia	n/	Decedent's Name (First, Middle, La.		Emery	v 01	iver		2. Date of De	eath	Year	3. Time of Death
	Medic Examin	al	4a. Facility Name (if not institution, give				1	r Location of Deat	November 1		2010 unty of Death	3:42 p м
1	EXAMI	er	Stella Maris	Hospice			Tim	onium		40.000	-	timore
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	Maryland Ba-f show tified at	rector	Usual Residence of Decedent 10a. State MD 10b. County		10c. City,	Town or Lo		timore			1	0d. Inside City Limits
	with the t s 23a or 2 ust be no	Funeral Director	10e. Street and Number 2618 Cyllburr	a Avenue, 1	st Fl	oor	10f. Zip Code 2	1215		10g. Citizen	of What Cour USA	ntry?
9036	1 and 2 should be filed within 72 hours after death with the Maryland if Heath and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent 8 Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.		1	Was Decedent of H f Yes, specify Cuba	an, Mexican, Puer	pecify Yes or No- to Rican, etc.)	1	Race - Americ Black, White, cify: Bla	etc.
21215-0036	hin 72 hoi ne. than "nat ie Medics	Completed	15. Decedent's 8 (Specify only highest gi Elementary/Seconday (0-12)			(Give I	lent's Usual Occup kind of work done of ONOT use retired)	during most of wo	rking		of Business Inc	ŕ
d 2	led within Hygiene. other tha ent, the I	Be C	11 17. Father's Name (First, Middle, Last)				Labor	Worker 18. Mother's Na	me (First, Middle	1	struct ame)	LON
ylan	should be file and Mental I 7 is marked o raumatic eve	₽	Tony Oliver					E	mma Holi	day —		
, Maryland	nd 2 shoul ealth and I n 27 is m er traums		19a. Informant's Name/Relationship (1 Sandra Oliver		ļ	19b. Mailir 2618	ng Address (Street Cyllbur)	and Number or Run Ave.,	ural Route Number 1st. flc	er, City or Tow Or, Ba	n, State, Zip (Itimor	e,MD 21215
Baltimore,	Page 1 and nent of Heal int: If item ; iry or other		20a. Method of Disposition 1 Burial 2 X Cremation 3 4 Donation 5 Other (Spec		cen	netery, cren	sition (Name of natory or other place urney Cre		Date 08/2010		on - City or To dbine ,	
Balti	permit. Page 1.8 Department of H Important: If ite any injury or ot		21. Signature of Funeral/Service Ucen	Dorota Ma - Wash			Name and Address PO BO					
	Physician/		23a. Part 1. Enter the disease, or com shock, or heart failure. List only of Immediate Cause (Final	one cause on each line	Э.	Do not ente	er the mode of dyin	ig, such as cardia	c or respiratory a			Approximate Interval Between Onset and Death
مميدها	Medical Examiner		disease or condition resulting in death)	a. ACQUIRI			<u>EFICIENC</u>	Y SYNDRO	<u>ME</u>			
	sit sd	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	b. Due to (or as	a consequer	nce of):						
	e executed cian and urial-transit	I— I	that initiated events resulting in death) Last	C. Due to (or as	a consequer	nce of):		· · · · · · · · · · · · · · · · · · ·				
209	icate by g physic s the b	ledic		d								
Box 68760	res that the death certificate be signed by the attending physici d be detached for use as the bu	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal o	death 3	Ectopic pregnand Other (specify)	Cy		23d.	Date of delive Month	ery Day Year
ds, P.O.	juires that the sin signed by the uld be detached		Part II. Other significant conditions of	contributing to death b	ut not result	ing in the u	nderlying cause gi	ven in Part I.	23e. Did t			ne cause of death?
of Vital Records,	The law requires ate has been sign page 2 should be	Completed by							24a. Was auto perfo 1 🗆 Yes		tb. Were autop prior to co death? 1 \(\square\) Yes	osy findings available mpletion of cause of
/ital	Physician: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 IX No	Hospital:		7/0-44	Oth	lace of Death (Che	eck only one) Home 5 Resi			HOSPICE
of	ng Phys fter this ineral di		27. Manner of Death 1 X Natural 5 Pending	28a. Date of inju (Month, Day	ry 28	8b. Time of injury	28c. Injur	y at	28d. Describe			HOSPICE
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral	Certificate:	2 Accident Investigatio 3 Suicide 6 Could not I 4 Homicide determined	De Blace of Inju		e, farm, stre	M 1eet, factory, office	Yes 2 No	28f, Location (City or Tox		mber or Rural	Route Number,
	e Hospital or 124 hours afte e Funeral Dir leted filled in	Medical	(Check 2 Medical Exam	vsician: To the best of niner: On the basis of e rese Practioner: To the	xamination a	nd/or invest	igation, in my opinio	on, death occurred	at the time, date	and place, and	due to the car	use(s) and manner stated.
	To the within To the Comp	2	29b. Signature and title of certifier	(D) (1)	P	- Inago, C	29c. Licens		2_		gried (Manth, I	
U			30. Name and address of person who				,	1111			1-110	-10
	Sta	te	JACKIE JONES, C 31. Date filed (Month, Day, Year)	2300 32. Registra	ar's Signatur	е	LLEY RD.	TIMONI	UM, MD 2	1093		
DU	Registr	ar	NOV 0 5 2010	End &	for	MI				· - · ·		

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			For		St	tate of N	1arylan	d / De	oartmer	nt of H	lealth	and M	lental Hyg	jiene	6.1.6	~ I	750
			State Registrar					C	ertificat	e of E	Death		F	Reg. No.	010	31	+758
	Physicia	n/	1. Decedent's Name	,	ast)								2. Date of Dea Month	Day	Year 201		ne of Death
	Medic	al .	Paulett 4a. Facility Name (if		is atmost	C.				eil		(D - 1)	November		0011	19	:05 AM
	Examin	er	Sinai Hos			,					Location C			4c. G	ounty of Death		
	Funeral		5. Social Security No		Sex	7. A	ge (In yrs. la	ast birthday) If Unde	r 1 Year	If Under	24 Hrs.	8. Date of Birth	1	9. Birth	place (S	ate or Foreign
	Director		227-66-5		1 🗆 M	2 XF	65	Yrs.	Months	Days	Hours	Min.	10 O.	Year) 4!	5 Cou	ntry)	VA
	how at	_	Usual Residence of 10a. State	Decedent 10b. County			10c. City	y, Town or	ocation							10d Insi	de City Limits
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	or 26	Funeral Director	10e. Street and Nun						10f. Zij	Code			Т	10g. Citize	n of What Cou	ntry?	
	s 23a nust b	era	2902 Key	yworth	Ave					2	1215				U.S.A		
	death item ner n		11. Marital Status		A	Vas Decedent	?	3. 1	. Was Dece	dent of Hi cify Cuba	ispanic Ori ın, Mexicar	gin? (Spec	cify Yes or No- Rican, etc.)	14	. Race - Ameri Black, White		ın,
36	after al", or xami	d b	1 ☐ Never Marri 3 🙀 Widowed		lf.	Yes 2 X Yes, Give Year or Dates.	No		1 🗆 Yes					Sp		ack	
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PAULETTE Iland 2121!	rintal Figer	일	17. Father's Name (I		t)								(First, Middle, I	Maiden Sui	rname)		
Z Z	ould I		Charlie 19a. Informant's Na		(Type, Pr	rint)		19h Ma	ilina Addres				Well Route Number,	City or To	wn State Zin	Code)	
O'NEIL, PAULETTE Baltimore, Maryland 21215-0036	permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Frankli					290	2 Key	wor	th A	ve,	Balti	móre	, Md	2121	.5
D'NEIL nore, M	of He If iten or oth		20a. Method of Disp		□ Remo	oval from Stat	20b. P	Place of Dis	position (Na	ne of other plac	e)	D	ate	20c. Loca	tion - City or 1	own, Sta	te
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Bal	permir Depar Impor any in		21. Signature of Ful	neral Service Lice	ensee	Adria	011		22. Name a M 3 6 8 1 4 3 6 8 1	Wab	H We	st Ave	, Balt	imor	e, Md	212	15
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	Medical Examiner		resulting in death)	4	a	Due to (or as	s a consequ	uence of):									
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Division of Vital Records, P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certificate:	4 Homicide	determine		Be. Place of Ir building, e	njury - At ho etc. <i>(Specify</i>	ome, farm,	street, factor	y, office			28f. Location (S City or Tow		lumber or Run	il Route i	Vumber,
	ospita hours uneral d fillec	Medical		Certifying P													
	the H hin 24 the Ft nplete	Mec	only one) 3	Medical Exa	urse Pra	ctioner: To th	examination e best of my	y knowledg	e, death occu	rred at the	e time, date	e and place	e, and due to the	cause(s) a	nd manner as	tated.	
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	•		30. Name and addre	race of pare on wh				239) /7:		I 15	5868	833	5	Noven	wher a,	dol	
(Dr. Ste							ede	re A	ve,	Baltin	nore	, Md 2	121	5

State Registrar 31. Date filed (Month, Day, Year)-

DHMH 17 Rev 7/2009

32. Registra's Signature

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State of Maryland / Department of Health and Mental Hygiene 2010 34759

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State 31. Date filed (Month, Dey, Year) 32. Registrar's Signature				nt Medical Exa	miner 111	Penn Street,	N N	MD 21201				
DISTRICTOR DELLEG SET STREET A MATERIA A MATERIA A MATERIA A MATERIA A MATERIA A MATERIA A MATERIA A MATERIA A				5 2010 32. Re	gistrar's Signatu	re A. A.a.	Red					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 29, 20 Î 0 Robert Preville Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice/Northwest Hospital Randallstown Baltimore 5. Social Security Number 8. Date of Birth (Month, Day, Year) Sept 4, 1937 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 1 M 2 □ F 213-36-5338 Director 73 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director MD Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 303 Pleasant Ridge Drive 21117 USA unk 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces Black. White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give 2 🗌 No unk Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: and Mental Hygiene. is marked other than "natural", 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) unk Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) ပ Department of Health and Ment. Important: If item 27 is marked any injury or cet-19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Northwest Hospital 5401 Old Court Road Randallstown, MD 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 10 Other (Specify) State Anatomy Board 655 W, Baltimore Street Baltimore, MD 21201 21. Signature of the Liser ce Licensee Ronald S. Walle, Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events Examir death certificate be executed resulting in death) Last Due to (or as a consequence of) physician a s the burial-t Completed by Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 □ Probably 4 □ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has perform 1 🗌 Yes **Division of Vital** or Attending Physician: 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer Natural 2 Accident 5 Pending 1 🗌 Yes 2 No Investigation Suicide 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital o within 24 hours at To the Funeral D Medical 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basic of examination and/or inventioning the state of the cause of 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Curtifying Nurse Practioner: To the best of my knowledge, death popured at the time, date and place, and due to the

3:00 AM M

unk

unk

unk

Birthplace (State or Foreign Country)

white

21133

Interval Between Onset and Death

Day

2 No

Year

10d. Inside City Limits

1 Yes 2 No

State Registrar 29b. Signature and title of certifier

Wonth, Day, Year)
V 0 5 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** ONKI DOTOBER 27 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** N/A 8. Date of Birth (Month, Day, Year) 12/31/1923 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director 242-26-9916 86 N. Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits al", or items 23a or 28a-f show Examiner must be notified at 1X Yes 2 No Director N/A MD Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 124 W. Franklin Street#902 21201 U.S.A. Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Was Deceden. _ Armed Forces? ¹ ☐ Yes 2 No Black, White, etc. filed within 72 hours after 1 Tes If Yes, Give 1 Never Married 2 Married 21215-0036 1 Yes 2 Xio Specify \$ Specify: 3 XWidowed 4 ☐ Divorced Black Year or Dates "natural", intal Hygiene. led other than "natura sevent, the Medical E Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Grade Bank Officer Retired Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be marked unk unk မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Felicia POlk(daughter) 8628 Jacks Reef Road, Laurel, MD 20724 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot once. 1X Burial 2 Cremation 3 Removal from State Lorraine Park Cem 11/02/10 4 Donation 5 Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee ^{-22. N}JÖSEPN H^{Facili}Brown JR. FUneral Home PA 2140 N. Fulton Ave.,Baltimore,MD 21217 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition **Physician** DRONARY resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and is the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death Day atter I for in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 1 TYes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 □ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy nas Yes 20 1 Yes certificate or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1
Inpatient Other: 1 ☐ Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 KER/Outpatient 3 □ DOA ၉ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No Accident 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

Division of Vital Records, P.O. Box 68760, I Director: A within 24 hours after or

To the Funeral Direct

completely filled in by the Hospital

Certification: 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 69 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ZACKARI 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month: Day, Year) 32. Redistrar's Signature State Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Erik Lamont Perry State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle Last) Physician/ 2. Date of Death 3 Time of Death Month Day October 27, 2010 Médical Examiner 1329 hrs Erik Lamont Perry 4a. Facility Name (if not institution, give street and number) b. City, Town, or Location of Death 4c. County of Death 3129 Marshall Hall Road Bryans Road Charles 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year I If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Director Hours 322-72-1585 1X M 2 F 36 07/07/1974 Country) IL. Usual Residence of Decedent 10a. State 2 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No 28a-f shov Charles Co. Indian Head permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3371 Lox Street 20640 U.S.A. Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Never Married 2 X Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: Black \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical timore, MD 21215-0036 vears Driver UPS 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be James Perry Melinda Smalley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ment of Health ar tant: If item 27 or other trauma Judy Gordon-Perry(Spouse) 3371 Lox Street, Indian Head, MD 20640 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State er place) H. Brown Crematory 1 Buriat 2 X Cremation 3 Removal from State 11/01/10 Baltimore, MD 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1052ph H_{Fu}Brown Funeral Homer PAMD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line Between Onset and /Madical Death a. Contact Gunshot Wound of abdomen Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of) rause Enter Underlying Couse (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. and Physician/Medical UNPENDED attending physician or use as the burial AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, cutcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death Live birth 3 Ectopic pregnancy Month past 12 months? Day Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed After this certificate has been a funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of autopsy performed' death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other Scene 1 🗸 Yes 28a. Date of Injury FOUND: 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Subject shot self __ Natural FOUND: 5 Pending Director: d in by the f 1 Yes 2 ✔ No Oct 27, 2010 Accident Investigation 1323 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 3371 Lox Street, Indian Head, MD within 24 hours a To the Funeral I determined (Specify) Parking Lot Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOME O.C.M.E. October 28, 2010 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Theodore M. King, Jr., MD. 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) kegistrar's Signature State NOV 05 2010 Registrar

DHMH 17 Rev 1/2001 **OCME 2006**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 10c, per FH g909 11/5/10 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Ke 2010 /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death 4b. City, **Examiner** 8. Date of Birth (Month, Day, **Funeral** Min. 1 ☐ M 2 💢 F **Director** 2 NOTTH Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Exemiter in ust be notified at 1XYes 2∐No Director imore Gwynn Oak 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race -American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No Black 3 ₩idowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Şecondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type. Print) (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) McAdoo 2120 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12010 Lansdowne Md Lion 21. Sign ture of Ing al Service License 22. Name and Address of Facility JOSEPH L. RUSS Fun 12222 W. North Ave. Funeral Home, P.A. 1e. Bayto, Md. 21216 atelle Hures K-M 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CEREBROVASCULAR **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. aftending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CARDIOVAC Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 2) **E**(V 1 ☐ Yes 2 ☐ No 1 □ Yes To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 5059107 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUSINESS REISTERSTOWN DRIVE CENTER UMA 31. Date filed (Month, Day, Year) strar's Signature State NOV 0 5 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	C	ertificate of Death	Reg.	. No.	34/04
			1. Decedent's Name (First, Middle, La	ist)		2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Nathanie l	Abnor Ro	oane Sr.	11	04 201	0 3:15a. ^M
	Examin		4a. Facility Name (If not institution, given		4b. City, Town, or Location of Death		4c. County of Dea	
			Manor Care Nur	sing Home	Catonsville		Balti	more
	Funeral		Social Security Number 6.	Sex 7. Age (In yrs. last birthd	ay) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	(ear) 9. Bir	thplace (State or Foreigr ountry)
	Director		229-20-6177	№ M 2 F 81	1	1 04	29	VA
	pu 🔪		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits
	aryla sho	ř	Tod. State Tob. County					1 ☑ Yes 2 ☐ No
	hе М	Director	MD NA	Balt	imore			
	vith t	ä	10e. Street and Number		10f. Zip Code	109	. Citizen of What Co	•
	s 23	Funeral	3301 Richwood		21244	-16 - 14 - 14 - 15 - 15 - 15 - 15 - 15 - 15	U.S.A	
_	item item	Ë	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	 Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R 	lican, etc.)	Black, Whit	
2	rs aft	by	3 ☐ Widowed 4 🎇 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2√ No Specify:		Specify: B	lack
5	hou	e	15. Decedent's E		ecedent's Usual Occupation	16	b. Kind of Business	
2	in 72	bet	(Specify only highest grant Elementary/Secondary (0-12)	ade completed) (G	ive kind of work done during most of working e. DO NOT use retired)			
7	r tha	Completed	9th grade	College (1-4or 5+)	Line Worker	En	mporia P	aint Co.
2	othe ent,	BeC	17. Father's Name (First, Middle, Last	1)	18. Mother's Name		_	
<u> </u>	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If the ath and Mental Hygiene. If marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Eventhand and other traumatic event, the Madical Eventhand and other traumatic event.	일	Andrew Roane		Mary Bla	ke		
ב כ	shou	-	19a. Informant's Name/Relationship	(Type. Print) 19b. M	ailing Address (Street and Number or Rural		City or Town, State,	Zip Code)
Ē	1 and 2 Health a tem 27 is		Debra D. Riley	-Daughter 330	Ol Richwood Ave,	Baltimo	ore. Md	21214
ב ב	other other		20a. Method of Disposition	20b. Place of Di	sposition (Name of Da crematory or other place)		c. Location - City or	
Ĭ	Page nent of int: If		1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci	J Hemovai from State	on Forest Vet 11/	12/10 0	Dwings M	ills. Mā
פ	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra		21. Signature of Funeral Service Lice		22. Name and Address of Facility March F H West 4300 Wabash Ave,			
	EE = W G		Mala 11	(auch				
			shock, or heart failure. List only	one cause on each line.	enter the mode of dying, such as cardiac or			Approximate Interval Between Onset and Death
Siz.	Physician		Immediate Cause (Final disease or condition resulting in death)	a. MYELODYS	PLASTIC SYN.	PROME	2	
,	/Medical Examiner		resulting in death)	Due to (or as a consequence of):				
		7.	Sequentially list conditions,	b. Due to lor as a copee wants of:				
	ted isit	ig	Sequentially list conditions, if the cause. Enter Underlying Cause (Disease or injury)	Due to or as a consequence of:				
	ertificate be executed ding physician and se as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consequence of):				
5	be e							ı
ò	icate phys the	Medical		▲d	· · · · · · · · · · · · · · · · · · ·			
		-	IF FEMALE:	23c. If yes, outcome of pregnancy			22d Data of da	livon
3	atter for u	sician	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal death 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of de Month	Day Year
5	the d y the ched	ysi	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown	Jacobs (specify)			
-		, Phy	Part II. Other significant conditions	contributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did tobac	cco use contribute t	o the cause of death?
3	uires sign d be	d by	HYPERTENSIVE	CARDIOVASCULAR.	DISEASE	1 ☐ Yes	2 ∑ (No 3 □ P	robably 4 🗌 Unknown
5	w requires t s been signe should be	Completed	OROPHARYNGE			04- 11/	045 347	
ַ בֿ	has ge 2 s	d E	UNOTHAN/1092	AL CHINDINIA	215	24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
5	i: Th licate r, pag							s 2 □ No
=	certif recto	Be	25. Was case referred to medical examiner?	Hospital:	26. Place of Death	-1-1-		
5	Phys this al dir	은	1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2 ☐ ER/Outpa 28a. Date of Injury 28b. Tim	tilent 3 1 DOA 4 2 Nursing Hom		ce 6 ☐ Other (Spe	ecify)
=	ding Physician: The Ph. After this certificate har funeral director, page		1 Natural 5 ☐ Pending	(Month, Day, Year) Injur	ry Work?	8d. Describe how	injury occurred	
2	ttenc death stor: ' the	icat	2 Accident investigatio 3 Suicide 6 Could not b	De 200 Place of Injury At home form		Of Location (Ct		love I Day to Moveday
2	or A after Direc in by	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	Street, lactory, onice	City or Town, S	et and Number or Fi State)	urai moute Number,
4	pital burs a eral i	_ [29a. Certifier 1 Certifying P	hyeinian: To the hest of my knowledge d	eath occurred at the time, date and place, a	and due to the carr	sea(e) and manner	ac etated
	Hos 24 hc Fun etely	Medical	(Check only 2 Medical Exa	miner: On the basis of examination and/o and manner stated.	eath occurred at the time, date and place, a or investigation, in my opinion, death occurre	ed at the time, date	e and place, and du	e to the cause(s)
	To the Hospital or Attendin, within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	Mec	29b. Signature and title of certifier	and manner stated.	29c. License number	29d	I. Date signed (Mon	th, Day, Year)
	- s - o					1		

Division of Vital Records P.O. Box 68760 D0059107

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11-04-2010

210 BUSINESS CENTER DRIVE REISTERSTOWN UMA

31. Date filed (Month, Day, -Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene 34765 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCTOBER Physician/ $20 \overset{\scriptscriptstyle{5}}{1}\overset{\scriptscriptstyle{6}}{0}$ ESTHER MADELINE RENNIE 9:42 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death UPPER CHESAPEAKE MEDICAL CENTER HARFORD BEL AIR 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🔀 E Months Days Hours Min. (Month, Day, Year ep. 2, 1 North Carolina 215-18-5492 Director 89 Sep. Usual Residence of Decedent or 28a-f shov 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No Maryland Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3001 St. Claire Drive Apt. 223 21009 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Yes 2X No 1 Yes 2 No Specify: 3 ₩ Widowed 4 □ Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ William (nmn) Coleman Cornelia (unk) Inman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 siment of Health a tant: If item 27 i Norma Wingate / Daughter 183 Princeton Ct., Advance, NC 27006 Department of Healt Important: If item 2 any injury or other once. or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2x Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Hilltop Service Corp. 11-3-10 Towson, Maryland 21. Signature of Funeral Service Licenses ²² Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, it my leading to immediate cause. Enter Underlying Due to lor as a consecution. The ng physician and as the burial-transil Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 \(\subseteq \text{ Yes} \) 2 \(\text{No} \) Day Pregnant at time of death 5 Other (specify) Month Vear 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of certificate has autopsy perform death? 1 ☐ Yes 2 ☐ No Yes 2 No or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 🗌 Yes <u>۾</u> 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide 1 🗌 Yes 2 🗌 No Investigation within 24 hours after deati To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Hattie Rouse Physician/ 2010 November 3 5:45 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 130 Slade 320 Baltimore Avenue. Apt. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days (Month, Day, Year) 243-12-1202 1 □ M 2 🔀 F 96 Director April 15. Usual Residence of Decedent or 28a-f show 10a State 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director MD Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 130 Slade Avenue, Apt.320 21208 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 0 þ 1 Never Married 2 Married should be filed within 72 hours after and Mental Hygiene. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black "natural" Completed 3 X Widowed 4 □ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour postartment of health and Mental Hygiene. Important; If item 27 is marked other than "natur any injury or other traumatic event, the Medical! 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 12 Music Therapist Healthcare 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eduard Pierson ည Esse Schuyler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) e Sudje/ Daughter E. Annette Rouse 130 Slade Ave., Apt.320, Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Final Journey Crem. 1 Durial 2X Cremation 3 Removal from State 11/06/2010 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) ce License Dorota Marshall 22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD 21203 21. Signature of Funeral Ser 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Renal Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Diabetes NMellitus Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Lue to (or as a consequence or) ASCVD Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last burial-Hypertension Physician/Medical Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Li Fetal God.

Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☒ No Dav Year ed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page performed? Yes 2 No 2 🗌 No Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 🎦 No Hospital Other: ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 🔀 Natural 5 Pendina s after death. 1 Yes 2 No 2 Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Techo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

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Comes

Cosmo Jacobs,

D 21328

4001 Liberty Heights Ave, Baltimore, MD 21207

November 3, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Nancy Jean Raver October 28, 2010 2:08AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Dove House Westminster Carroll Social Security Number 8. Date of Birth (Month, Day, You May 5, 1 6. Sex **Funeral** 7. Age (In vrs. last birthdav) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 1 ☐ M 2 🗓 F Hours Director 218-28-3105 78 1932 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 💢 No MD Carrol1 Finksburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 31 W. Maver Drive 21048 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🂢 No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: "natural" Completed 3 Widowed 4 X Divorced Year or Dates. White other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Nurse Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Parks F. Hoover Georgianna Ford Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald L. Raver Son W Mayer Drive Finksburg, MD permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other it Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Lorraine Park Cemetery 11/1/10 Woodlawn, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death metastahu Physician/ CAZCIN OMA 4 MONLY Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to for as a consequence of the attending physician and ched for use as the burial-transit Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

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4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy 5 Other (specify) in the past 12 month Unknown g 🗌 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CHRONIC OBSTRUCTURE DUMOMAY 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has performed? Yes 2 No death? After this certificate 1 ☐ Yes 2 ☐ No To Be (To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 🗹 Other (Specify) 🐠 (Pucson 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DQA 27. Man of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniurv work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined within 24 hours a Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) tranco K-0106/36/01 JEEVEN TIL MO D31660 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

THOMA

32. Registrar's Signature

STONER

AURUL

CUES MINISTER

MAKIGLARE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			30. Name and address of person w		e of death (It	em 23a) (Type, P			0		N.11 s.	_	1 200	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death edent's Name (First, Middle, Last) 2. Date of Death Physician/ November 2,2010 9:44 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 3402 Wildcherry Road Baltimore Windsor Mill Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign 8. Date of Birth Funeral Days Hours (Month, Day, Year) 1 M 2 - F 49 Director 215-78-5605 08 Apr Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be nortified any once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Windsor Mill Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3402 Wildcherry Road 21244 United States Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Wesley Betty JoAnn Denton Street 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty JoAnn Varni /Mother 205 Wedgewood Drive Washington, NC 27889 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Beltsville, Maryland Chesapeake Crematory 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Alternatives MO1585 Rober Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of Cause (Disease or iinjury that initiated events the burial-tran and Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No Unknown 9 Unknown death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes **Division of Vital** 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28c. Injury at 28d. Describe how init MN 10 work? 1 Natural 5 Pendina N 2 No after death Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatu

Registrar

DHMH 17 Rev 7/2009

State

of death (Item 23a) (Type, Print)

of person who completed

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31. Date filed (Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death O Z Day Physician/ 1425 2010 Medical Facility Name (if not institution, give street and number City, Town, or Location of Death 4c. County of Death Examiner of altimore Marylan Liversita f Under 1 Year If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** March 15 1928 1 ★ M 2 🗆 F 82 Virginia 226-22-6195 Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director MD Glen Burnie Anne Arundel 1 Yes 2 K No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7223 Judy Road 21060 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married þ If Yes, Give WW III 1 Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry should be filed within 72 h and Mental Hygiene. 7 is marked other than "I Elementary/Seconday (0-12) College (1-4 or 5+) General Foreman Bethlehem Steel 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Department of Health and Menta Important: If item 27 is marked: any injury or other traumatic eve ၉ Elizabeth Fowler Edwin Shacklock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7223 Judy Road Glen Burnie, Maryland 21060 Susan Shacklock wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Crownsville Veterans Cemetery 11/08/2010 Crownsville, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Cully Polyniak Funeral Home P.A. Licenses 3204 Mountain Road Pasadena, Maryland 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Jostidum difficile Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** <u>cauachnoid</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Juthall 1840 Tameles CERTIFICATION APPROVED BY MEDICAL EXAMINER attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy☐ Pregnant at time of death 5 ☐ Other (specify) ☐ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by diabetes, hypertension, COPD 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? certificate 1 Yes 2 No ☐ Yes 2 No completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No 1 → Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After ☐ Natural 5 Pending 10.18.2010 1930 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Boute Number City or Town, State) 1223 June 1 3 ☐ Sulcide 4 ☐ Homicide determined City or Town, State) Residence Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier R107416 11.02.2010 death (Item 23a) (Type, Print) 22 S. Greene St. Baltimore MD 212001 31. Date filed (Month, Day, Year) State

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Registrar

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Baltimore, Maryland 21215-0036

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Box

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Records,

Division of Vital

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E	Funeral Director		5. Social Security Number 212–50–0818		Sex □ M 2 XX	7. Age (<i>In yr</i> s. i	last birthday) Yrs.	If Under 1 Year Months Days			of Birth h, Day, Yea 21	1950	9. Birthp Coun	olace (State or Foreig try) MD	n
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17 m 円 30x 6876	Hospital or Attending Physician: The law requires that the death certificate be executed 4 hours after death. Funeral Director: After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregiin the past 12 month 1 Yes 2 No 9 Unknown	nant ns?		irth 2 🗀 Feta ant at time of a	al death 3	Ectopic pregnar Other (specify)	су			23d. Dat	te of delive	ery Day Year	
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			30. Name and address of	person who	completed cause	of death (Item	-23a) (Type, P	rint) /5/	77 1	14		1121	201		_
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 11-2-2010 /Medical 4a. Facility Name (If not institution, give street and no 4b. City, Town, or Location of Death 4c. County of Death **Examiner** timore htwater Cours Juin 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours 09526-2682 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ NO Funeral Director 10e. Street and Number 10g. Citizen of What Country? USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No ģ Specify: 3 Widowed 4 Divorced Black Be Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natur any Injury or other traumatic event, it e Medical any Injury or other traumatic event, it e Medical once. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. QO NOT use retired) Elementary/Sapndary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ဂ္ Known 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) laverner 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of permetery, crematory or other place) mount 11-5-2010 Boltimore MU 22. Name and Address of Facility Waughn C. Greene Funeral Services 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Randallstown MD 21133 berty Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** reta Statt pancreatic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) ed by the attending physician and detached for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown filled in by the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 1 Natural 2 Accident 5 Pending Investigation 1 □Yes 2 □No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Goldbloom mp 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 10:30 PM Virginia Viola Sawyer H 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Rosedale Baltimore FRANKLIN Square Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🗓 F Hours Min. Month, Day, 1923 218-12-2046 87 Yrs. Maryland Director Usual Residence of Decedent 28a-f shov 10c. City, Town or Location death with the Maryland 10a. State 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director Parkville Baltimore MD 1 Yes 2 No 10e. Street and Number 10f, Zip Code ò 10g. Citizen of What Country? Funeral items 23a 21234 USA 2936 Manns Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Exeminan injury or other traumatic event, the Medical Exeminantic event, the Medical Exeminant in Item Medical Exeminatic event, the Medical Exemination or other traumatic event, the Medical Exemination in Item Medical Exemination in Item Medical Exemination in Item Medical Exemination in Item Medical Exemination in Item Medical Exemination in Item Medical Exemination in Item Medical Exemination in Item Medical Exemination in Item Medical Exemination in Item Medical Exemination in Item Medical It 🗌 Yes 2 🔀 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: white Specify: Completed 3 ₩ Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United Insurance Elementary/Seconday (0-12) College (1-4 or 5+) Key punch operator 12 Company of America Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Viola Walker Daniel Bailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2048 Cox Road-Jarrettsville, Maryland 21084 Penny German-daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place,
Moreland Memorial Park Burial 2 Cremation 3 Removal from State Nov. 6, 2010 Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signare of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Preumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Failure nearT Congestive Sequentially list conditions, Examiner Due to (or as a consequence or). it any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N Director: After this certificate I bin by the funeral director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To 1 🔲 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number YULING ZHANG, MD D70605 Nov, 03, 2010

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

mo

32. Registrar's Signature

4000

FRANKLin Square DR Balto md 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Willie Sligh		1- For State Registrar	State of Mar		partment c <i>ertificate c</i>				20 Reg. No.	10 34771
Physicia Medical Examir	an/	1. Decedent's Name (First, Mic Willie Slic						Date of De Month		3. Time of Death r 2012 hrs
		4a. Facility Name (if not institu	ution, give street and	id number)			own, or Location of		4c. County o	of Death
Funeral Director		5. Social Security Number 249 – 86 – 0590	6. Sex	60	s. last birthday) Yr	<u> </u>	er 1 Year If Under	24Hrs. B. Date of B	Birth (MM/DD/YYYY)	9. Birthplace (State or Foreign Country) SC
nd show any		Usual Residence of Decedent 10a. State 10b. Count MD Prir		rge Ul	ty, Town or Loca pper Ma	ation arlbo	oro			10d. Inside City Limits 1 Yes 2 No
h the Maryla 3a or 28a-f : otified at or	Dire	10e. Street and Number 10506 Woodl	awn Blv	^r d		10f. Zip (Code 1774		10g. Citizen of Wha	at Country?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	3 Widowed 4	Married Arme	e Year 1968 –	-70 1	Yes, specify Yes 2	Cuban, Mexican, F		Afri Specify:A	can mer.
1036 vithin 72 hours ene. er than "natur Medical Exam	mpleted	15. Decedent's Education (Specific Reports of Specific Reports of	12) Colleg	grade completed)	during n		Occupation (Give kir king life. DO NOT us		16b. Kind of Bus	ŕ
MD 21215-0036 at 2 should be filed within 7 at 2 should be filed within 7 at 2 should be filed within 7 at 2 should be filed within 3 marked other than a umatic event, the Medica	Be	17. Father's Name (First, Middl A.W. Sligh 19a. Informant's Name/Relation			I 40h Maili	- ~ Addedee	Ber	Name (First, Middle, nice Met	ts	
MD 2 nd 2 shoul alth and h m 27 is n summatic		Daisy Washi		Sister	1125	5 Fox	Crost 1	er or Rural Route Nu Rd, Colum	mbia,SC	29223
Baltimore, permit. Pages I an Department of Hea Important: If iter		4 Donation 5 Other	Specify:	val from State We		ther place)	apt.CH	11/9/10	Newber	City or Town, State
		21. Signature of Funeral Service			22. I 5 1	Name and A	elair R	Hari P. d,Balt.,	Close F MD 2120	Svs, PA 6-5105
Physician /Medical :xaminer	i	23a. Part I. Enter the disease, failure. List only one caus Immediate Cause (Final diseas or condition resulting in death)	ise on each line. ise a. <mark>Multiple</mark>			the mode of	dying, such as card	diac or respiratory ar	rest, shock, or hear	rt Approximate Interval Between Onset and Death
		Sequentially list conditions, if any, leading to immediate	b	as a consequence of						
d sit	튑	cause. Enter Underlying Caus (Disease or injury that initiated events resulting in death) Last	se c.	as a consequence of						2.0
50, te be executed ysician and burial - transit	lical E	UNPENDED	dAMENDE	ĒD						
	5 II	IF FEMALE: 3b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 U	1 Liv	res, outcome of pregive birth regnant at time of denknown	2 Fe	etal death Other (Specia	3 Ectopic p	regnancy	23d. Date of d Month	delivery Day Year
ires that the signed by the detached	à	Part II. Other significant cond	titions contribution	ig to death but not r	resulting in the I	underlying o	ause given in Part I			oute to the cause of death? Probably 4 Unknown
of Vital Records, ag Physician: The law require this certificate has been si meral director, page 2 should b	Completed	25. Was case referred to medic	cal			26	3.Place of Death (Cl	1 🗸 Yes	psy pri ormed? de	ere autopsy findings available for to completion of cause of eath? Yes 2 No
Vital hysician this cert	ě L	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatient		Othor	Nursing Home 5	Residence 6	Other: Scene
Division of Neal or Attending Phas after death. After to led in by the funeral			ending FOUN vestigation Nov 2	Pate of Injury Ionth, Day,Year) ND: 2, 2010	2Bb. Time of I FOUND: 2006 hrs		3c. Injury at Work?	o Driver auto		
Divis To the Hospital or At within 24 hours after dwithin 4 hours after completely filled in by	Ser	4 Homicide dete	etermined (Speci	Place of Injury - At h	ad / Highway	у		or Town, S S/B Rt 5 (Bra	State) anch Ave), Brandy	
To the Hos within 24 h To the Fur completely	10	(Check only		sis of examination a				e, and due to the cau- rred at the time, date		
	ž 2	29b. Signature and title of certif					O.C.M.E.		29d. Date signed November 3	d (Month, Day, Year) 5, 2010
N N	1	30. Name and address of perso Ana Rubio MD. As	on who completed ca ssistant Medica			Street, Ba	altimore, MD 21	1201	<u>. </u>	
Sta Registr	te ³ ar	31 Date filed (Month, Day Year	0 5 2010	. Registrar's Signatu	ture A	back	1			

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Betty Ellen Schilling 2010 15 November 08 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carrol1 Dove House Westminster 8. Date of Birth (Month, Day, July 11 9. Birthplace (State or Foreign Country) Ohio Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral Days Hours 1 □ M 2 □XF 76 298-28-7778 Director 1934 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Carrol1 Westminster 1 🗌 Yes 2 🗓 No 10g. Citizen of What Country? USA 10f. Zip Code 10e. Street and Number 21157 Completed by Funeral 58 West Winters St. Apt. A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) domestic Elementary/Seconday (0-12) 12 homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Rufus Dayton Fields Elsie Ming 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 988 Eckard Ct., Westminster, MD 21158 Mrs. Mary Ann Samples (daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State Colerain, Ohio Holly Memorial Garden 11-8-10 4 Donation 5 Other (Specify) 22. Name and Address of Facility Haight Funeral Rome & Chapel Signature of Funeral Service License break Hought Sterkers P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line. CIRFHOSIS Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (qr as a consequence of) MUORILIC STENTO HEPATITIS **Examiner** Securitally list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) signed by the attending physician and defacted for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death g Unknown 9 Unknown Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIABETES MELLINIS I 2 No 3 Probably page 2 should peen CORPOHNIS DISENSE 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has performed? Yes 2 No 2 **N**o 1 Yes 25. Was case referred a medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE (2 Hospital: 1 Yesé 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Man r of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 24 hours after death Funeral Director; completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier ifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Centifying Nurse/Fractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 3 [only one) 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Philip Ruzbarsky M.D., 125 Airport Dr., Westminster, MD 21157

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

arke

32. Registr s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34776 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Thomas Larry Spencer 25 PM Medical 010 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Maryland Health C 010 cial Security Number If Under 1 Year Ulf Under 24 Hrs **Funeral** 7. Age (In vrs. 8. Date of Birth 9. Birthplace (State or Foreign 212-42-7908 **Director** 64 Hours 049/15/ 1946 Yrs Maryland Usual Residence of Decedent fshow 10b. County Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits or 28a-f MD N/A 1X Yes 2 ☐ No Baltimore 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral items 23a 108 Diener Place Apt102 21229 filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? ō 1 Never Married 2 Married Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usuai Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Maryland 2121 12th Grade College (1-4 or 5+) Tech Johns Hopkins hosp. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leonard R. Ray Mary Sue Spencer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 937 S. Marlyn Ave., Baltimore, MD 21221 Daquann Spencer(son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Joseph rematory or other at ANd Crematory 1 Burial 2 Cremation 3 Removal from State 11/01/10 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21 Anne and Address of Facility 21 Anne and Address of Facilit 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Grand Gr Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Yes ed by the a detached f 1 L Yes 2 L 9 Unknown To the Hospital or Attending Physician: The law requires that within 24 hours after death.

To the Funeral Director: After this certificate has been signed I completed filled in by the funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) မ 1 🗌 Yes Other; 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident work? 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 X certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge death conumed at the first Jake and place, and July 10 Jul (Check only one 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month. Day, Year) 052739 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MbCareSustem, PernyPoint State 5 2010 Registrar

sencer,

SOUTH

Baltimore,

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O | O | O | Amend Items 25,27,28a-f per me. g909, 11/04/2010dhb | Reg. No. For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 2330 M nel 22,2010 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Mary lama timore 5. Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1**M** M 2□ F Months Days 219-40-5752 Director ما ept 20 1942 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow the Musical Examiner must be notified at by Funeral Director 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Iteme 23a 2525 Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after I ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 2 No ŏ 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced "natural", lac Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if item 27 ie marked other than "na any injury or other traumatic event, the Mental 2006. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) borer Maryland 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle 2 10mas lurner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Woodmont 15650-C Sister saltmore Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) butus 8-30-10 21. Signatur of Funeral Service Licensee 22 Name and Address of Facility Vaughn & Greene 5151 Bal Amore augmo Nationa 23a. Part1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory afres shock, or he art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Kidne /Medical CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of): Examiner umonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed physicien at s the burial-t Due to (or as a consequence of): Box 68760, by Physician/Medical ettending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) ed by the e o 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Donknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy page 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 XYes 2 1 ဥ Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) Medical Certification: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After atural 5 Pending investigation death. Subject fell down steps 1 Yes 2 No 2 XAccident 1990 Unknown^M within 24 hours after death
To the Funerel Director:
completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3507 Lucille Ave. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Home Baltimore, MD 21215 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 30. Name and address of person eted cause of death (Item 23a) (Type Print) 31. Date-filed (Month, Day, Year) 32. Pagistrar's Signature State park Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year William B. Thomson ctober Medical 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death TENINSYLA KEGIONAL HICAMICA SALISBYAL 8. Date of Birth (Month, Day, Apr 8, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Days 1 🕅 M 2 🗆 F Months Hours Delaware Director 218-26-6603 1933 Usual Residence of Decedent or 28a-f shov 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2x No MD Worcester Ocean City 10e. Street and Number 10g. Citizen of What Country? Funeral 304A 141st Street 21842 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married 1 Yes 2 If Yes, Give 2 X No 1 ☐ Yes 2 🗓 No Specify: Specify: white Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 in and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 12 salesperson heating & AC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Robert Hall Thomson Myrtle Elizabeth Dickerson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health as Important: If item 27 is any injury or other trau Patricia Thomson/spouse 304A 141st Street Ocean City, MD 21842 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 X Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 21. Signature of Funeral Serv Ronald Wade 655 W. Baltimore Street 2 Ja. Part Enter the disease, or compilitations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, Pleart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). attending physician and I for use as the burial-transit Due to (or as a consequence of) Physician/Medical that the death certificate be IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 Yes 2 No 9 Unknown Month Day the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed a 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 又 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate To the Hospital or Attending Physician: 1 within 24 hours after death. To the Funeral Director: After this certifics completed filled in by the funeral director, t 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 X No Other: မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work? 1 Yes 2 🗌 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

29b. Signature 3

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records.

Division of Vital

and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician/ 4:54 A M November 2010 Thomas Robbie Μ. Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore Union Memorial Hospital 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1074877950 1 **X**M 2 □ F Maryland 60 218-56-0624 **Director** Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10b. County 10a. State must be notified at Director Yes 2 No Baltimore N/A MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Completed by Funeral 23a U.S.A. 1300 E. Lanvale street Apt704 21201 er than "natural", or items the Medical Examiner mu 14. Race - American Indian, Black, White, etc. Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hyglene. Fant: If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner munor or other traumatic event, the Medical Examiner munor. 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 \(\subseteq \) No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12)
12th Grade College (1-4 or 5+) Day Care Center Floor Tech Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Rosalee Moore Milton Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 617 N. Robinson St., Baltimore, MD 21205 Carol Barnes(Cousin) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place)
And Crematory F/H 11/04/10 Department of Important: If it any injury or o once. 1 Burial 2 X Cremation 3 Removal from State Baltimore, MD 4 Donation 5 Other (Specify) and Address of Facility own Jr., Funeral Home 2PA N. Fulton Ave., Baltimore, MD 21217 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Anproximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ d disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner week Hypotensian Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Tes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral directors. 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be 2 Accident
3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie AT 2438946 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bultimore wen Gliter, 140 201 East University 31. Date filed (Month, Day, Year) 32. Registr State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	aryland /		artment of He tificate of De		Mental Hy	rgiene Reg. No. 2 (10	34780
			Decedent's Name (First, Middle)	, Last)					2. Date of De	eath		3. Time of Death
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	Funeral Director		212-28-7707	1 M 2 AF		Yrs.		Hours Min.		ay, Year)	Cour	place (State or Foreign htry) ryland
	nd how at	ř	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation					10d. Inside City Limits
	larylar Ra-f s ified	Director	Maryland Anne	Arundel	,,,,,,		Glen Bur	nie				1 ☐ Yes 2 ☒ No
	or 28 or 28 e not	Dir	10e. Street and Number	Artificer			10f. Zip Code	1116		10g. Citizen of	What Cou	ntry?
	with s 23a ust b	Funeral	1625 Lorim	er Road			21	061		US	SA	
	death item ner m		11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. V	Vas Decedent of Hisp f Yes, specify Cuban,	anic Origin? (S Mexican, Puert	pecify Yes or No- o Rican, etc.)		ce - Americ	
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Š	d 2 shalth a		Roxanne Kelba				7933 Belh					· '
			20a. Method of Disposition 1 Burial 2 Cremation		20b. Place	of Dispo	sition (Name of natory or other place)		Date	20c. Location		
Ĕ	Page 1 ment of tant: If it tury or o		4 Donation 5 Other (S				ematory,In	c. Nov	. 9,201	D Balt	imor	e, Maryland
Baltimore, Maryland 21215-0036	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service	2ng/ /			. Name and Address					me, PA
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l,	and the same		23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final			I /	/a / I de mode or dyling, a	Such as Cardiac	/)	<i>k</i>		Approximate Interval Between nset and Death
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DIVISION	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending I completed filled in by the funeral director, page 2 should be detached for use as		4 Homicide determ			arm, stre	et, factory, office		28f. Location (S City or Tou	Street and Numb vn, State)	er or Rural	Route Number,
	ospita hours ineral	Medical	29a. Certifier 1 Certifying	Physician: To the best of r	ny knowledge	, death o	ccured at the time, da	ate and place, a	l nd due to the ca	use(s) and mann	er as state	d.
	the H hin 24 the Fu	Me	only one) 3 L Certifying	xaminer: On the basis of ex Nurse Practioner: To the b	est of my know	vor investi wledge, d	gation, in my opinion, eath occurred at the tir	me, date and pla	at the time, date a ice, and due to th	and place, and du- e cause(s) and ma	e to the cau anner as st	use(s) and manner stated. ated.
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			20 Name and address of the	m ////	oth (Itama 22 '	(Terr. 5	11/2	301		11/04	12	010
			30. Name and address of person v	Difference cause of de	MŁO –	(Iype, Pi	Directo	Fill.	PD 5+	161	12.	1 . MA
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NOVEMBER 4, 2010 7:40 a.m.

REGINALD WILLIAMS

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			For State	State of Ma	arylan				d Mental Hy	giene	2010	34781
			Registrar 1. Decedent's Name (First, Middle, Las	of)		Cer	tificate of l	Death		Reg. No.		1
	Physicia			,	10				2. Date of Dea	Day	Year	3. Time of Death
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	Funeral		5. Social Security Number 6. S			st birthday)	If Under 1 Year Months Days	If Under 24 H		h v Yearl	g. Birt	hplace (State or Foreign
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	at at	or	10a. State 10b. County	_	10c. City	, Town or Loc	cation					10d. Inside City Limits
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	the A a or 2 be no	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Cit	izen of What Co	untry?
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Š	be filed within 72 hours after death with the Maryland antal Hygiene. ked other than "natural", or items 23a or 28a-f show tic event, the Medical Examiner must be notified at its event, the Medical Examiner must be notified at	Completed	15. Decedent's E	ducation			lent's Usual Occup			16b. Ki	nd of Business I	ndustry
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Baltimore, Maryland 21215-0036	permit. Page 1 a Department of H Important: If ite any injury or ott		21. The of Fundal Service Licens	∕ ee		W1	. Name and Addre LLIAM C	ss of Facility BROWN C	OMMUNITY	FUNE	ERAL HOM	E P.A.
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Š M	death ne atte ed for	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at			Other (specify)	-			Month	Day Year
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_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2 Medical Exam	sician: To the best of iner: On the basis of expressioner: To the l	kamination	and/or invest	igation, in my opini	on, death occurre	ed at the time, date a	nd place,	and due to the c	ause(s) and manner stated
	North comp	_	29b. Signature and title of certifier	Jun-		-	29c, Licenson	e number 4372	_ 1	29d. Dat	e signed (Month	, Day, Year)
			30. Name and address of person who	completed cause of de	eath (Item	23a) (Type, P					1	·
	- Av-		TARIQ MAHMOOD, MI 31. Date filed (Month, Day, Year)	2300 DUL			Y RD. T	MONIUM.	MD 2109	3		
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	AH 17 Rev 7/20	nna		,	/	17						

State of Maryland / Department of Health and Mental Hygiene

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Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Arthur William Worthington October 0 P^{M} 2010 6:00 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 146 Woods Way E1kton Ceci1 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, **Funeral** Birthplace (State or Foreign Country) Months Days Hours 1 M 2 □ F Director 192-12-6908 87 May 29, 1923 Pennsylvania Usual Residence of Decedent Department of Health and Mental Hygiene, Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar in ust be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No E1kton MD Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21921 USA 146 Woods Way by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dupont Company 12 engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Isabelle Kerns Arthur William Worthington ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Fox Lane Newark, DE 19711 Bette Balder/daughter 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Nonation 5 Other (Specify) 21. Signatur of Funeral Syrvice Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 23a. Part i Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ementia Unknaon /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause En Cluse (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed burial-tran Due to (or as a consequence of): attending physician for use as the buria Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Day Year Month 5 ☐ Other (specify) ed by the a detached f P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No 2 □ No 1 □Yes 1 ☐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: 4 \sum Nursing Home Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) After this funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: / 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20023322 Jacker 8 n/D 10.29.2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S.S. SACHDEN MD, 126 A, E High 32. Registrar's Signature ElbEn MD21921 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #26 Per Phy G909 11/05/10 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar 34783 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SARAH 0574 Month Year WILSDA 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 126 Cottage Grove Drive Pasadena 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** Days Min. 1 🗆 M 2 🗷 Months Hours Director 93 36-01-1098 191 New Jersev Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f showing any injury or other traumatic event, the Medical Examples. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Pasadena Anne Arundel Maryland 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21122 126 Cottage Grove Drive 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Dept of Corrections Corrections Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Stoddard Clarajane William Joseph Simpson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 126 Cottage Grove Dr, Pasadena, Md 21122 19a. Informant's Name/Relationship (Type, Print) (dtr) Taryn Wilson-Wheatlèy 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State Lehigh Valley Cre 11 '04 '2010 Hellertown, PA21. Signature of Funeral Service Licenses Name and Address of Facility Cully-Polyniak Funeral Home 104 Mountain Road, Pasadena, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate erval Between et and Death Immediate Cause (Final EART Physician SPASE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner lan Secusi dally not so dations, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Unknown Day Year signed by the a Id be detached f 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy eral Director: After this certificate ifilled in by the funeral director, pag 2 No 1 Yes Yes 25. Was case referred to medica æ 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: 110ME 은 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5XXResidence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after of To the Funeral Direct completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check

State Registrar

DHMH 17 Rev 7/2009

only one 29b. Signature and title of certif

me and address of perse

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31. Date filed (Month, Day, Year)

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ho completed cause of death (Item 23a) (Type, Print)

32. Registrar's Si

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3 🗆 Certifying Nurse Practions To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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29d. Date signed (Month, Day, Year)

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State Registrar

Mary G. Ripple MD.

31. Date filed (Month, Day, Year)

Deputy Chief Medical Examiner 32. Registrar's Signature

Knoun

ORIGINAL COR

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 28e, f, per me, g909, 11704/2010dhb Certificate of Death 1 - State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Williams Day 23 2010 ariar 1:45 PM ctober Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death of Baltimore timore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 M Months Hours Min, (Month, Day, Yea Country) Director Alabam Usual Residence of Decedent show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location any injury or other traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits 1 Yes 2 No items 23a or 28a-f TIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Hlank Funeral W 2120 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Completed by Black, White, etc. 1 Never Married 2 Married ò 2 No ☐ Yes 1 Yes 2 No Specify If Yes, Give 3 Nidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) amstrets de Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 alto 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ☐ Burial 2 Cremation 3 ☐ Removal from State cemetery, crematory or other place, 27/2010 17 MORO 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility NOA 14021201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a conseque ORU CERTIFICATION APPROVED BY MEDICAL EXAMINER Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 2 No ျ 1 Anpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) OCT 23; 7010 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? ☐ Natural 5 Pending 1 Yes 2 No 2 Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number City or Town, State) Raltimore, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Rural Route Number, **Ethland Ave.** determined Home 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practionar To the Lest of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check any one 29d. Date signed (Month, Day, Year)
October 24, 2010 29b. Signatu 29c. License number Komero threnas, MD, MPH, Sinai Hospital of Baltimore 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Minerva 31. Date filed (Month, Day, Year) State egistrar's Signatur NOV 0 4 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 Margaret A. Wheatley November 6:07A. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Balto. Riverview Nursing Home Essex Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Hours Min October 9 Director Maryland ,1932 212-78-3728 78 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Examiner must be notified at 10d. Inside City Limits Director 1X Yes 2 □ No N/A Baltimore City Md. 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? Funeral 3801 Ravenwood Avenue or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 X Never Married 2 Married þ 1 Ves 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: permit. Page 1 and 2 should be filed within 72 hours aff Department of Health and Mental Hyglene. Important; If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exan Completed 3 - Widowed 4 - Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Disabled Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Wheatley Eva M. Rafferty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Seitz P.O.A. 12920 Community Drive Middle River, Md. 21220 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 Kcremation 3 Removal from State 4 Donation 5 Other (Specify) Bayview 11-3-2010 Balto. Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9<u>705 Belair Road</u> Nottingham. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day 4 Pregnant a 9 Unknown Pregnant at time of death Year within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 1 L Yes 2 L Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by nem 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Universing Home 5 Residence 6 Other (Specify) Hospital: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No 14 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 □

State Registrar

29b. Signature and title of certifie

MALIKA

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar Signature

ASTERN BLUD,

29d. Date signed (Month, Day, Year)

M.D- 21221

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ Richard Eugene Wolfe 2010 November Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Parkville 8800 Walther Blvd. Apt. 2201 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Birthplace (State or Foreign Country) **Funeral** Days Months Hours 85 **Director** 220-14-9450 Axemenn, Usual Residence of Decedent Show or 28a-f shov notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Parkville Maryland Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ō "natural", or items 23a o edical Examiner must be Funeral 21234 United States 8800 Walther Blvd. Apt. 2201 should be filed within 72 hours after death and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces' Black, White, etc ģ 1 Never Married 2 Married 1 √ Yes 2 □ No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 27 is marked other than "natu traumatic event, the Medical 16a Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Westinghouse/Glenn L. Martin Logistical Engineer 12 . Page 1 and 2 should be filed wit ment of Health and Mental Hygie tant: If item 27 is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marjorie Wooner Henry Franklin Wolfe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8800 Walther Blvd. Apt. 2201 Parkville, Maryland 21234 Pat Wolfe (Scouse) Department of Healt Important: If item 2 any injury or other t other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Nov. 06,2010 Parkville, Maryland Parkwood Cemetery 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services—Parkville 8800 Harford Road Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be ed by the attending detached for use as IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year is certificate has been signed by director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by high cholesterol 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral r 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 61785 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dixon Walther Blud Parkville MD 31. Date filed (Month, Day, Year) State NOV 0 5 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Emily Anne Weimerskirch Month Dav а м November 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Silver Spring 2602 Finch Street Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 340-05-1297 1 M 2 K F Months Days (Month, Day, Year) 95 Director 1915 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "nothers" any injury or other transitions. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State FL Director 10c. City, Town or Location 10d. Inside City Limits , Sarasota Sarasota 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3812 Wilshire Circle West 34238 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: White 3 X Widowed 4 Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Registered Nurse Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Frederick Wade Hazel Rowe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Anne Rae Wisniewski/Daughter 2602 Finch Street, Silver Spring, MD 20902 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crem. 11/5/2010 Woodbine, MD 22. Name and Address of Facility Dorota Marshall Cremation Services 13. Baltimore, MD Maryland PO Box 1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician ZHEIMER disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 month signed by the atte Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy 2 🗌 No 1 Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Tyes 2 X No Other: ျ **Daughter** 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specific After this 27. Manner eath 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 5 Pending atural injury Accident
Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier (Check ination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the Certifying Nurse Practioner: To the st of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 009834 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) I-ARRAGUT AUG KEUSINGTON, MD 20881 ROSENBAUM 3720 32. Registrar's Signatur State 5 2010 Registrar

DHMH 17 Rev 7/2009

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			Registrar	204)		Ce	rtificate of L	Death		Reg. N	lo.	
	Physicia Medio		1. Decedent's Name (First, Middle, La Katherine	Elizabeth	A	nger			2. Date of De Month	D	Year Sol	3. Time of Death
	Examin		4a. Facility Name (if not institution, give		/		4b. City, Town, or	Location of Deat		- 1	c. County of Dea	
	Funeral		COASTAL HOSPI 5. Social Security Number 6.	Sex 7. Age	E LF	AKE ast birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Bir	th	U, Co/	rthplace (State or Foreign
	Funeral Director		076-22-9846	□ M	3	Yrs.	Months Days	Hours Min.	(Month, Da 03/05/	y, Year) 192	7 F1	orida
ERINE	land s how d at	ξ	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation	·				10d. Inside City Limits
ê	Mary 28a-f notifie	irec	Maryland Wicom	ico	Al	len	Lieu 71 G i					1 🗆 Yes 2🎗 No
THE	with the s 23a or ust be r	Funeral Director	10e. Street and Number 3399 Allen Road	Ē			10f. Zip Code 21810			10g. C	USA	ountry?
215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fur	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🎛 Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates.			Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🔀 No	n, Mexican, Puert	pecify Yes or No- o Rican, etc.)		14. Race - Ame Black, Whit Specify:	
5 5	2 hou "natu edical	plet	15. Decedent's (Specify only highest of	Education rade completed)		16a. Dece (Give	dent's Usual Occup kind of work done of OO NOT use retired)	ation Juring most of wor	king	16b.	Kind of Business	Industry
	ithin 7 ene. r than	Con	Elementary/Seconday (0-12)	College (1-4 or 5	+)		c/operato			b	oarding	kennel
√ C mind 24	filed wall Hygi other	æ	17. Father's Name (First, Middle, Last,				,	18. Mother's Na	me (First, Middle,	Maider	n Surname)	
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\mathcal{A} \gtrsim Maryland	nd 2 shou ealth and n 27 is m er traum		19a. Informant's Name/Relationship (Gail Rayfield/da	** .		19b. Maili PO I	ing Address (Street a	Allen, M	ral Route Numbe 21810	er, City o	or Town, State, Z	ip Code)
Baltimore,	le 1 an t of He If iten or oth		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3	Removal from State	20b. F	lace of Dispo emetery, crea	osition (Name of matory or other plac		Date		Location - City o	
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	Medical Examiner		resulting in death)	Due to (or as a	consequ	ience of):			,			/
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Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live Birth 4 Pregnant at 9 Unknown	2 🔲 Feta	death 3	☐ Ectopic pregnand ☐ Other (specify)	у			23d. Date of de Month	Day Year
0.	hat the ed by detacl	y Ph	Part II. Other significant conditions					en in Part I.	23e. Did to	obacco	use contribute to	o the cause of death?
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) C	r this eral dir	은	1 ☐ Yes 2 💥 No 27. Manner of Death	28a. Date of injur	v	28b. Time o	f 28c. Injun	4 ∐ Nursing F ≀at	lome 5 Resident Resid		6 A Other (Speciary occurred	city) TTE Spree
ouc	ath. r: Afte	icat	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation		; Year)	injury	M 1 🗆	? Yes 2 🗆 No				
ivisi	l or Atte after de Directo	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		ry - At ho . <i>(</i> Spec <i>ify</i>	me, farm, str)	reet, factory, office		28f. Location (S City or Tox	Street a	nd Number or Ru e)	ural Route Number,
	Hospita 24 hours Funeral	Medical	(Check 2 Medical Exar	ysician: To the best of a niner: On the basis of ex rse Practioner: To the	kamination	and/or inves	stigation, in my opinio	on, death occurred	at the time, date a	and plac	ce, and due to the	cause(s) and manner stated
	To the vithin To the compl	Σ	29b. Signature and title of certifier	120)	,omouge,	29c. License	number		29d. D	ate signed (Mont	h, Day, Year)
	\ <u>`</u> `		fregori M	. Della	-6,	mi). DZ	9505			0 - 16	-10
	150	/	30. Name and address of person who					REUD V	ne i	261	10000	MDDIENI
	Stat	te	GREGORIO M 31. Date filed (Month, Pay, Year)	2010 32. Registra	r's Signal	ure	hale	IVOKK)	V10.75	/17 L	17171111/	MD 2180
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death Octobe 4b. City, Town, or Location of Death 4c. County of Death HAGERSTOWN WASHINGTON , MD If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year 1 M 2 X F Months Min Sep. 10b. County 10c. City, Town or Location Maugansville 10f. Zip Code 10g. Citizen of What Country?

34790 1. Decedent's Name (First, Middle, Last) Physician/ ELLIE ANN AMATO 1701 PM Medical 1a. Facility Name (if not institution, give street and number) Examiner WASHINGTON COUNTY HOSPITAL 5. Social Security Number 9. Birthplace (State or Foreign Funeral Pennsylvania Director 195-18-4558 Usual Residence of Deceden ral", or items 23a or 28a-f shov Examiner must be notified at permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if them 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examinar must have acted. 10a State 10d. Inside City Limits Director Maryland Washington County 1 Yes 2 No 10e. Street and Numbe Funeral 13820 Weaver Ave. 21767 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. White Specify: 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Personal Residence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Dominick Liberatore Basilica Sabatini 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jamie Paci-daughter 14239 MArsh Pike Hagerstown, MD 21747 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 10-26-2010 Brownsville, PA Taylor Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home e of Funeral Service Licenses 331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician CHRONIC OBSTRUCTIVE PULMONARY years Medical resulting in death) Due to (or as a consequence of) Examiner CONGESTIVE HEART FAILURE veaus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): ATRIAL FIBRILLATION led by the attending physician and detached for use as the burial-transit Cause (Disease or linjury Vears that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical RENAL INSUPPICIENCY vears that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Petal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Day Pregnant at time of death Month Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be de ş Hospital or Attending Physician: The law requires 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific.
completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 🚺 No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined n 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier SE Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 29b. Signature and title of certifier R128088 10/22/2010 Katem Smith 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Kate M. Smith CRNP Hagerstown, MD 21740 SH-10 1126 Opal (t. 31. Date filed (Mont)

State Registrar

gistrar's Signature

10-08258 Samuel Lopez /	Aguil		pe or Print i tate of Maryla							_egibl	- ATT		3479	
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Physici Medical Exam		1. Decedent's Name (First, Midd		007	Agui	lar		-	2. Date of I Month	Death Day	Yea	ır	3. Time of Death	
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. In profram: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	I Director	10e. Street and Number 8239 14th A	venue A	Apt.302		10f. Zip Cod 2 ()78	3			tizen of Wh Guat			
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Box 68760, e death certificate buthe attending physical for use as the butter butter as the butter butter as the butter butter as the butter b	Physician/Medica	past 12 months?	4 Pregn	irth ant at time of death	, - =	death r (Specify)	3	Ectopic pregr	ancy	İ	Month	Da	ay Year	
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	İ	30. Name and address of person Pamela E. Southall, M		e of death (Item 23 Medical Exami	,	Donn St	act F	Saltimoro	MD 21201					
i St	ate			gistrar's Signat		-	ee(, E	Baltimore,	NID 2 1201					
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	_	Registrar 1. Decedent's Name (First, Middle,Last)	٠.	Certi	ificate o	Deat	n		15	Re Date of Deat	g. No.		
Physicia Medical Examir		Veronica D. B	iddle							Month October 16	Day 5, 201		3. Time of Death
		 Facility Name (if not institution, give street a 8949 Clark Road 	and number)			4b. City, 1 Berlir		Location of De	ath			County of Death Vorcester	
Funeral		Social Security Number	7. Age (In	n yrs. las	t birthday)		er 1 Yea		_	. Date of Birt	h(MM/	DD/YYYY) 9. Birt	
Director		208-70-8263 1 M 2 Usual Residence of Decedent	X _F 22	2	Yrs	Month i.	ns Day	s Hours	vlin.	07/31,	/198	Foreig 38 Pé	nnsylvania
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Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Director	8949 Clark Road					2181	1			og. Citiz	USA	u y r
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Divisi To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical	one) 2 Medical Examiner: On the b	asis of examinat	-									
To To con	ğ	and mar 29b. Signature and title of certifier	nner stated.			29c	. Licens	e number		T	29d. D	ate signed (Mon	h, Day, Year)
		Allen Brasoll	M				O.C.I	M.E.			Octo	ber 17, 2010	
12	ŀ	30. Name and address of person who completed		•								————	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 25,27,28a-f per me g910,12/17/2010dhb Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month \$ 2010 POL BUNTING GLADYS Ε. Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death isbure NICOMICO If Under 24 Hrs. 8. Date of Birth
Hours Min. DEC. 8, 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🗶 F Months Days DELAWARE Director 101 214-28-2965 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important I flem 27 is marked other than "natural", or items 23a or 28a-f sho minoriant if liem 27 is marked other than "natural", or items be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director BISHOPVILLE WORCESTER 1 Tes 2 No MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Baltimore, Maryland 21215-0036 Funeral 13303 HATCHERY ROAD USA 21813 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: WHITE If Yes, Give Year or Dates Specify. 3 ♥ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME 12 HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည DERRICKSON MARY CHARLES WEST 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 391, BISHOPVILLE, MARYLAND 21813 WILLIAM E. BUNTING/SON 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 5 Other (Specify) BISHOPVILLE, MARYLAND BISHOPVILLE CEMETERY : 10/19/10 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. he death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to for as a consequence of: cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal deat
Pregnant at time of death in the past 12 months?

1 Yes 2 No Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? s after death. I **Director:** After this certificate Division of Vital completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 X Accident 5 Pending Subject fell 10/07/2010 2X No **Unknown**M 1 Tes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number. City or Town, State) 13002 Jaryis Rd. Bishopville, MD 21813 determined To the Hospital within 24 hours a To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 10-16-10

Registrar
DHMH 17 Rev 7/2009

State

5302 CHINABERRY DR. SALISBURY, MD 21801

50. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LLOSO;

32 Registrar's Signature

M.

GREGORIO

31. Date filed (Mont)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DORIS AUGUSTUS BAKER 2010 OCTOBER 5:45 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death FORT WASHINGTON HEALTH & REHABILITA ION CTR FORT WASHINGTON PRINCE GEORGES 5. Social Security Number If Under 1 Year 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days MAY 15. 1 🗆 M 2 🗶 F 088-42-6836 TRINIDAD Director ľ919 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland must be notified at Director MARYLAND PRINCE GEORGES TEMPLE HILLS 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3420 RICKEY AVENUE 20748 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Examiner Black, White, etc. ò 2 Yes 2 X No 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: BLACK "natural", Completed 3 Widowed 4 Divorced of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) DRESS MAKER CLOTHING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Filmportant: If item 27 is marked o any injury or other traumatic eve anse. ည JOHN BAKER ETHEL GRAHAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LEISTER PAUL MAYNARD/NEPHEW 15512 HELEN DRIVE, ACCOKEEK, MARYLAND 20607 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State BRINSFIELD-ECHOLS CREMATORY OCT. 30, 2010 CHARLOTTE HALL, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) Signal e Fun al Service Licensee

LILLA C. THORNION JOHNSON M00583 22. Name and Address of Facility THORNTON FUNERAL HOME, P.A. 3439 LIVINGSION ROAD INDIAN HEAD MD 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ BREAST CARCINOMA disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** DEMENITA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or se a consequence of,: or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 L Fetal deat
Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Day Month Vear ate has been signed by the page 2 should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by GENERALIZED DEBILITY 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate 2 🗌 No 1 🗌 Yes Yes within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, 25. Was case referred to medica æ 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 **X** No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural Accident 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the pasts of examination and/or investigation, in my opinion, a coat resource at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

NB | State

Registrar
DHMH 17 Rev 7/2009

30. Name and address of person

31. Date filed (Month, Day, Year)

POTTER

EDGER J.

no completed

M.D.

32. Registrar's Signature

ause of death (Item 23a) (Type, Print)

142955

acres

12017 FORT WASHINGTON ROAD

FORT WASHINGTON, MARYLAND 20744

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^D1^y9 201^o0 october 5:55 P M BRADLEY ANITA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death ROCKVILLE MONTGOMERY CASEY HOUSE If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth **Funeral** DEC. 15 1 □ M 2 🗓 F Days Hours Min °1952 MARYLAND 57 Director 212-62-1848 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified ** once. Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 🏋 Yes 2 □ No PRINCE GEORGE'S FORT WASHINGTON MD 10e. Street and Number 10g. Citizen of What Country? Funeral USA 9587 FORT FOOTE ROAD 20744 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. b 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 No Specify: Specify: Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) COOK PRIVATE 12**T**H Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ PROCTOR ICLAIN ODELLE BRADLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9587 FORT FOOTE ROAD FT. WASHINGTON, MARYLAND 20744 HARRIETTA M. PROCTOR/DGT. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State RESURRECTION CEMETERY 10-27-2010 CLINTON, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician. LUNG CANCER disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or imjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 X No Day Month Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Trobably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes Be B 25. Was case referred to medical eral Director: After this certific filled in by the funeral director, 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 🗶 No 은 4 Nursing Home 5 Residence 6 V Other (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b 29c. License number 29d. Date signed (Month, Day, Year) R143201 OCTOBER 21, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

DEBORAH MILLER

OCT 2 5 2010

RN 6001

MUNCASTER ROAD ROCKVILLE, MARYLAND

20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 432 AM Physician/ Month OC+ Thelma ro wine 2010 Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOWARD COUNTY GENERAL HOSPITAL Howard Columbia 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Ye, 5/7/1934 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 M 2 F Country 578-50-9690 Director 76 Washington. DC Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Maryland Prince George's Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral should be filed within 72 hours after death with and Mental Hygiene. is marked other than "natural", or items 23a 705 Iverington Street 20785 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 6 1 ☐ Yes 2 🖾 No If Yes, Give à 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify. Completed 3 Widowed 4 Divorced Black. Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Registered Nurse Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve John Henry Smith Clara Staten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ivanhoe Street SW # 101 Washington, DC 20032 Wanda Dixon / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/26/2010 Heritage Memorial Waldorf, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Alexander S. Pope, P.A.
2002
2017 Pennsylvania Ave. S.E. Washington, D.C. 20020 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final nteretton Mydeardia Physician/ disease or condition Medical resulting in death) (or as a consequence of) Examiner Card 10 myo math beima Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami Athens scientic distrie Cardio vascular and Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Vear Pregnant at time of death the Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed t 23e. Did tobacco use contribute to the cause of death? by atera Schensis Division of Vital Records, Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Circhias this certificate 1 🗌 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 D No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 Natural (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No. Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined

State Registrar

Medical

29a. Certifier

only one)

3 29b. Signature and title of

WILLAM

OCT 2 5 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 2 To the F

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) 19110

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) October Physician/ 19, 2010 Birdie Lucille Brown 1:45 A. M Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Prince Georges Clinton Southern Maryland Hospital 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Year 1930 Days Hours Min av 25, 1 □ M 2 🕱 F Washington, D.C. 80 Yrs. 577-42-5821 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f sho 10a. State within 72 hours after death with the Maryland traumatic event, the Medical Examiner must be notified at Director 1XXYes 2 No Suitland Prince Georges Maryland 10g. Citizen of What Country? 10f, Zip Code 10e Street and Number 6 3613 Silver Park Drive; Apt. 303 20746 United States Funeral items 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?

1 Yes 2 No 6 1 Never Married 2 Married Completed by **Black** Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) I Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Domestic Domestic Engineer 12th grade should be filed vand Mental Hyg ris marked othe Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Brown Sarah Ruth Thompson Daniel permit. Page 1 and 2 should be Department of Health and Men Important: If Item 27 is marke any Injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20746 19a. Informant's Name/Relationship (Type, Print) 3613 Silver Park Drive; Apt. 303; Suitland, Maryland Patricia Lucille Hill (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Oct. 26, 2010 1 X Burial 2 Cremation 3 Removal from State Fort Lincoln Cemetery Brentwood, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility R. N. Horton Company Morticians, Signature of Funeral Service License Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ TABOLIC Medical resulting in death) (or as a consequence of): **Examiner** KIDNE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for the funeral completed filled in by the funeral director, page 2 should be detached for the funeral completed. Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death g Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Tes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Tes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Be examiner? Other: 2 No 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 2 28b. Time of 28a. Date of injury 28d. Describe how injury occurred 28c. Injury at 27. Manner of Death Certificate: (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending М 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29b. Signature and title of certifi

State Registrar eath (Item 23a) (Type, Print)

on who completed cause of

nth, Day, Year **5 2010**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1,18619a Per Phy SFH G909 11/15/10 The Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Baker Hazel Oliver Baker Physician/ 1^{59} , 2010^{60} October 5:35a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Boyds 17125 Darnestown Rd 8. Date of Birth (Month, Day, Year) Nov 14,1923 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 □ M 2 🗓 F Days Hours Director Nov 499-24-1374 86 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits Director MD Yes 2 No Montgomery Boyds 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17125 Darnestown RD 20841 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. 3 → Widowed 4 □ Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Journalism Writer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elma Mason Furlong Richard Dewey Oliver 19a. Intermant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17125 Darnestown Rd, Boyds, MD 20841 Barbara Richardson/Daughter 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit, Page 1 a
Department of H
Important: If ite
any injury or ot 10-22-2010 4 ☐ Donation 5 ☐ Other (Specify) St Gabriels Cem Potomac, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons, INC 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 8 Months Ovarian Carcinoma Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transial. cause (Disease or imjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 XNo 3 Probably 4 Unknown Completed is certificate has been si director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 Yes 2 No 1 ☐ Yes 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27, Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year, 29c. License number D23308 Oct 19,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6420 Rockledge Dr. #4100 Bethesda, MD 20817 Victor M. Priego, M.D. 31. Date filed (Month, Day, Year) 2. Registrar's Signature State OCT 22 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) **Physician** /Medical 4c. County of Death 4b. City Town, or Location of Death street and number Facility Name (If not institution, give **Examiner Baltimore City** The Johns Hopkins Hospital 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)

MARCH 23,1947 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** 1 **X**M 2 □ F MARYLAND 214-48-1168 63 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10a State 10b. County 1 ☐ Yes 2 No Director CENTREVILLE or 28a-f si notified QUEEN ANNE MD 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number тs 23a о must be 21617 USA 310 DEAN ROAD Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 **X** No If Yes, Give 11. Marital Status Examiner 1 Never Married 2X Married Baltimore, Maryland 21215-0036 ö 1 Yes 2 No Specify: Specify: ģ WHITE 3 Widowed 4 Divorced Year or Dates "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education the Medical (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed with nent of Health and Mental Hygiene. Int; If item 27 is marked other than FOOD SERVICE SALESMAN item 27 is marked other other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DORIS HORSEMAN ALBERT BERGA ္ဝ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 310 DEAN ROAD, CENTREVILLE, MD 21617 SUSAN CAROL BERGA/ WIFE 20a. Method of Disposition
1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Pages 1 Department of F Important: If it any injury or o once. CHESAPEAKE CREMATION
CENTER 20, OCT. 2010 4 Donation 5 Other (Specify) STEVENSVILLE, MD 21666 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate 23a, Part 1. Enter the disease, Interval Between Immediate Cause (Final disease or condition resulting in death) Due to (or s a consequence of) **Physician** /Medical ysemetow chokeystitis Examiner Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying Cause (Disease or injury Examiner no requence of Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If ves, outcome of pregnancy 23d. Date of delivery 23h. Was decedent pregnant Live birth 2 Fetal death 3 - Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 Other (specify) 2 🗌 No Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopey has 2 🗌 No certificate 25. Was case referred to medical examiner? 26. Place of Death Check only one Be Hospital: 1 Inpatient Other: 4 🗆 Nursing Home 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 1 🗌 Yes ၉ After this 27. Mann of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: Injury 5 Pending investigation n 24 hours area of the Funeral Director, After and the funeral filled in by the fu M 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2

To the 1

comple 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

31. Date filed (Month,

DHMH 17 Rev 1/2001

Registrar

parks

Registrar's Signature

ler

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 1230 PM Maess 10 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1822 Johnson Rd. Anne Arundel Annapolis 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign Days Min Dec 16 1 □ M 2 🛣 F Hours Maryland Yrs 1925 84 **Director** 219-16-0408 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f Maryland Anne Arundel Annapolis 1 ☐ Yes 2 X No 10e. Street and Number 6 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 1822 Johnson Rd. 21409 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Medical Examiner Black, White, etc. ö ρ 1 Never Married 2 Married within 72 hours after Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. "natural", Specify: Completed 3 ₩ Widowed 4 Divorced Black 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. New York Elementary/Seconday (0-12) College (1-4 or 5+) the 12th 2yrs Para Professional Public Schools permit. Page 1 and 2 should be filead Department of Health and Mental Hy, Important: If item 27 is marked other any injury or other traumatical once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Herman Johnson Ethel Stansbury 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin Payne(Daughter) 714 North Chanel Dr. Glen Burnie, Md. 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Maryland Veteran 10-20-10 Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) WMame RARGE of RecilitSons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. MO0483 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Das h Immediate Cause (Final Physician/ disease or condition resulting in death) MONT Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to lur as a consequence of attending physician and for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 pronths? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Month Day Year Pregnant at time of death the g | Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Jas page performed? Yes 2 W certificate 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 1 Tyes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA ieral Director: After this filled in by the funeral dii 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Hospital or Attending Watural 5 Pending injury 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier pleted 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b, Signature and title of certific 29c. License number 29d, Date signed (Month, Day, Year)

Q7 3

3altimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

State Registrar

31. Date filed (Mont)

Amerila MD

2003

egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 9 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Neil Edward Burns 2010 October 10:46 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 604 McKinsey Park Drive Unit 302 Anne Arundel Severna Park Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) May 27, 1931 9. Birthplace (State or Foreign **Funeral** Days 1 X M 2 □ F 412-44-7652 79 Yrs Director Tennessee Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Severna Park 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 604 McKinsey Park Drive Unit 302 21146 USA 12. Was Decedent Ever in U.S.

Armed Forces? Korean

1 ☑ Yes 2 ☐ No War

If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White "natural", 3 Widowed 4 Divorced Year or Dates mit. Page 1 and 2 should be filed within 72 hour sartment of health and Mental Hygene. ordant. If item 27 is marked other than "natur injury or other traumatic event, the Medical injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Director of Operations Defense Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Neil Edward Burns Wilkie Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 604 McKinsey Park Drive Unit 302 Severna Park, MD Irene M. Burns / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of IImportant: If ite
any injury or ot 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20, October MD Veterans Cemetery Crownsville, MD 2010 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home 21. Signature of Funeral Service Licensee 495 Ritchie Hwy. Severna Park, MD 21146 23a. 1 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Pilmohary Fibrosis disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) and I-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown been signed by the should be detached 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? perform Yes 2 No 2 🗌 No 24 hours after death.

Funeral Director: After this certific eted filled in by the funeral director, or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 📉 No 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗀 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier To the Hosp within 24 hor To the Funer completed fil

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Box 68760

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Records,

Division of Vital

Registrar DHMH 17 Rev 7/2009 29b. Signature and title of certifier .

31. Date filed (Month

eral Bech, My

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 9 2010

2001 Medical

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

D46052

Parkway annapolis

29d. Date signed (Month, Day, Year)

10/18/60

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 15°, 2010 Thomas John Burch 9:25 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Mandrin Hospice House Harwood If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8 Date of Birth Funeral 1 🗶 M 2 🗆 F Months Days nonth, Bay, 214-36-3367 Director 70 T940 Washington, DC Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 💢 No Maryland Prince George's Lanham 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 7000 Presley Road 20706 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 7 No 1f Yes, Give 1963—
Year or Dates 1965 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. United States Elementary/Seconday (0-12) College (1-4 or 5+) Iron Worker Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Norman Augustine Burch Margaret Mary Haufman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Gloria J. Burch/ Wife 7000 Presley Road Lanham, MD 20706 20a. Method of Disposition
1 ★ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Veterans Cemetery 4 Donation 5 Other (Specify) 10/22/2010 | Crownsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityRobert E. Evans Funeral Home 16000 Annapolis Road Bowie MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final Physician/ disease or condition <u>a Lung Cancer</u> Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Property of the continuation of the certificate has been signed by the attending physician and Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4XX Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 X No 2 🗌 No 1 Tes Be 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) examiner? Hospice Hospital Other: 1 ☐ Yes 2 ☐XNo မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🕅 Other (Specification of the control of the c 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Accident 1 Yes 2 \ No Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

October 18th, 2010

Box 68760 P.O. I Records, Division of Vital completed filled in by the

> State Registrar

DHMH 17 Rev 7/2009

only one 29b. Signatu

> <u>Sajeev Anand, M.D</u> 7343-A Hanover Parkway Greenbelt, MD 20770

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Gordon H. Brown, Jr. 2010 11:10PM October Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Severna Park 114 Bellemeade Drive 5. Social Security Number 8. Date of Birth
(Month, Day, Year)
Oct. 19, 1955 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral 9. Birthplace (State or Foreign 1 ₹ M 2 □ F 54 Mary land Director 215-64-4583 Jsual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director MD Anne Arundel Severna Park 1 ☐ Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 114 Bellemeade Drive 21146 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🛣 No Black, White, etc. þ 1 Never Married 2 X Married 72 hours after Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", If Yes Give Specify 3 Divorced 4 Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Benfield Elementary/Seconday (0-12) President 12 Trucking. Inc. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Patricia Blanchfield Gordon Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Debbie Brown / Wife 114 Bellemeade Drive Severna Park, MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State October 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Baltimore, MD Metro Crematory, INC. 2010 21. Signature of Fundral Service Licensee 22. Name and Address of Facility Barranco & Sons, Severna Park Funeral H Severna Park, MD 21146 P.A. 495 Ritchie Hwy 23a. Part 1. Soter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Pnysician/ ANCER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence oi). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and and -tran that initiated events Due to (or as a consequence of): resulting in death) Last physician a sthe burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy
5 Other (specify) ____ Month Pregnant at time of death Day Year signed by the a d be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page death? performed' Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: 4 \square Nursing Home \mathcal{A} Residence 6 \square Other (Specify) 1 🗌 Yes မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and fly 29d. Date signed (Month, Day, Year)
October 15 2010 D08118 Medical Parkwey Annylom 21401

State Registrar

STANLEY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ATKINS M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Perry Eugene Butler State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day October 24, 2010 2123 hrs **Medical Examiner** BUTLER PERRY EUGENE 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Prince George's Hospital Center Cheverly Prince George's 5. Social Security Number 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign WASHINGTON 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Days Hours Director 215-72-6898 1 XM Country) 2 F 23 1962 DC 48 Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygene.
ant: If item 27 is marked other than "natural", or items 22a or 28a-f sho aptif item 27 is marked other than "natural", or items 20a or 28a-f sho aptif exhibited 22a more, must be notified at once. DISTRICT HEIGHTS PRINCE GEORGE'S MD Director 10e. Street and Numb 10g. Citizen of What Country? 20747 USA 6502 HALLECK STREET Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married Yes BLACK 3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2X No specify. Specify: ð 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) PRIVATE COMPUTER TECHNICIAN 2+ 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be RICHARD E. BUTLER **EVELYN HARLEY** 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2016 BARLOW PLACE LANDOVER, MARYLAND 20785 MARIE BUTLER/DGT. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State crematory or other place) RESURRECTION CEMETERY 10/30/2010 CLINTON, MARYLAND Donation 5 Qther Specify 22. Name and Address of Facility 21. Signature Funeral ervice Dicense J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death Pulmonary Thromboembolism Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last g physician and the burial - transit ca 23a,27 per me gll 1-20-11 vt X UNPENDED **AMENDED** Physician/Medi The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the use as t 1 Live birth 2 Fetal death signed by the attending be detached for use as 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed certificate has been s ector, page 2 should l 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death? ✓ Yes 2 No ✓ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) director, Be Hospital: 1 Inpatient Other4 Nursing Home 5 Residence 6 Other 2 FR/Outpatient 3 DOA 1 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Certification Division 1 X Natural 1 Yes 2 No Pendina tþe Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) (Specify) Homicide 29a. Certifier 1 [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. OCME October 25, 2010 30. Name and address of person who completed se of death (em 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) istrar NOV 0 1 2010 32. Registra s Signa are Registrar

OHMH 17 Rev 15001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item = State Registrar#8, per fh, 10/29/10, ca Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Bivens Sr. Holton October 18 2010 Brewington /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** omers Manokin Manor Anne 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1**X** M 2□ F 75 Yrs. 214-32-1600 maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinal must be invited at 1 ☐ Yes 2 ☑ No Director Chance Maryland Somerset 10g. Citizen of What Country? 10e. Street and Number U.S. Rd. Mahlon frice 21821 10848 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No Brewington Specify: Specify: Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) House Keeping Salisbury Univers. 11th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Price Grace Carter Bivens ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bivens - wife Ave , Salisbury, md 21801 Towson Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Chance, md St. charles Omc. Cemetery 10/23/10 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee Anthony E. wal Avé, Princess Anne Mar 1853 Hampdon 30639 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Preuwuid Sequentially list conditions, if any, leading to immediate cluss. Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Ye ar in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of autopsy performed? 1 ☐Yes 2 ☐No 1 ☐Yes 2 ☐No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending 1□Yes 2□No investigation 2 ☐ Accident filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10/19/10 047094

State Registrar 1415

5. DIVISION Sheet SALISBURY MD 21804

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State 10–21–10 Registra Amend#26 PerPhys PGCT Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last, 2010 Physician/ October 6:20 P Mary Elizabeth Brown Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Prince George's Bowie 13222 llth Street 8. Date of Birth
(Month, Day, Year)
Feb. 1, 1917 9. Birthplace (State or Foreign . Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. **Funeral** Days Country) Maryland Months 1 □ M 2 🛂 F 93 Feb. Director 215-20-3033 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show an injury or other traumatic event, the Medical Examiner must be notified. 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No Bowie Prince George's Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral United States 20715 13222 11th Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces
1 ☐ Yes 2 ☐ Black White, etc. 1 Never Married 2 Married 2 🔀 No by Afriçan 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates <u>American</u> 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Assistant Supervisor Government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Thomas Asbury Hall, Sr. Agnes Duckett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13222 11th Street Bowie, Maryland Janice Marlene Colbert/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State October 19 2010 10 Laurel, Maryland Stewart Funeral Home, Inc. 4 ☐ Donation 5 ☐ Other (Specify) Maryland National 22. Name and Address of Facility 21. A nature of Funeral Servi Licky ee 4001 Benning Road, NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line Approximate Interval Between or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death rate nas been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: atient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) ျ 1 Yes After this 28c. Injury at work? 1 ☐ Yes 2 ☐ No Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending ☐ Accident Investigation s after death 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Hospital 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed within 2. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar antil

me and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER 3:40 P M **EDWARD** BEAMON 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death PRINCE GEORGE'S DOCTOR'S HOSPITAL LANHAM Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Sex 1 █ M 2 □ F Months Hours TEXAS MAKCH D3O ear 929 Director 454-30-9913 81 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director PRINCE GEORGE'S 1 XYes 2 No SPRINGDALE 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA 3539 EDWARD STREET 20774 items 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No ARMY If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 0 ð 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify:BLACK "natura!" 3 🗌 Widowed 4 🗓 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) YRS GOVERNMENT POLICE OFFICER other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MATTIE WIGGS SAMUEL BEAMON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HUCKLEBERRY DRIVE COLUMBUS, MISSISSIPPI JOHN BEAMON/SON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of any injury or 1 NBurial 2 Cremation 3 Removal from State MD VETERANS CEMETERY 10/22/2010 CHELTENHAM, MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 7474 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury sician and burial-transit Exam that the death certificate be executed that initiated events Due to (or as a consequence of resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ for in the past 12 months? Pregnant at time of death 1 Yes 2 9 Unknown 2 No signed by the a g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 2 No 3 Probably 4 Unknown cate has been signated to page 2 should to Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of death? perform I ☐ Yes 24 hours after death.

Funeral Director: After this certifical eted filled in by the funeral director, I Physician: 25. Was case referred to medical Division of Vital æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann Death 28a. Date of injury 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certificate: (Month, Day, Year) or Attending 1 Natural 5 Pending 1 Yes 2 Accident
3 Suicide
4 Homicide 2 🗆 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completed file Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title 3 29d. Date signed (Month, Day, Year) 201 30. Name and address of person who completed cause of death (Item 23a) 09

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Monti D<u>a</u>y Physician/ 2010 Cooper Gary Robert Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** SAUSBUR anilo asional If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1 🛛 M 2 🗆 F 11-3-1954 Maryland 214-66-7985 **Director** 55 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits with the Maryland the Medical Examiner must be notified at Director 1 X Yes 2 No Fruitland MD Wicomico 10f. Zip Code 10g. Citizen of What Country? ō 10e. Street and Number Funeral items 23a USA 21826 413 Forest Drive death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Force Black, White, etc ò <u>Ş</u> 1 Never Married 2 X Married ☐ Yes 2X No Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. White If Yes, Give Specify "natural", Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Printing Company 12 Pressman other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mentall Important: If item 27 is marked o any injury or other traumatic eve ၉ Robinson Ruth Cooper Robert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 413 Forest Drive, Fruitland, Maryland 21826 Claudia Lynette Cooper - Wife 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-19-2010 Salisbury, Maryland Parsons Cemetery Fundal Service Lice 22. Name and Address of Facility Bounds Funeral Home Salisbury, Maryland 21804 Main Street, Ε. . Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence **Examiner** Somentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Exami requires that the death certificate be executed -tran and Due to (or as a consequence of): -burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has 1 Yes 2 No certificate 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes 2 1 No ER/Outpatient 3 DOA မ 1 Inpatient 2 🗆 To the Hospital or Attending Physiwithin 24 hours after death.

To the Funeral Director: After this of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Under Institute Institut (Check 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

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Registrar's Signatur

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 17, 2010 Year October 1:35 P Nettie Campbell Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Magnolia Nursing Home Prince George's Lanham 8. Date of Birth (Month, Day, 1 Birthplace (State or Foreign Country)
 NC Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 □ M 2 X F Days Hours 95 ^{Year} 9<u>15</u> Director 243-12-0521 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 No Prince George's Lanham MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20706 7008 Riverdale Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 A No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married þ 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 3 Midowed 4 ☐ Divorced Specify: Black Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Jennit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Meany injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeping 12th grade Domestic Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nettie Bostic Henry Chambers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James A. Pittman - So N 7008 Riverdale Road Lanham, MD 20706 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Community Rest Ceme. 10/23/2010 Red Springs, NC 4 Donation 5 Other (Specify) 22. Name and Address of Facility Marshall-March Funeral Home Signature of Funeral Service Licensee 4217 9th Street NW Washington, DC 20011 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, fock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cerebrovascular Accident disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ P in the past 12 months? Day Month Year Pregnant at time of death 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 ☐ Yes 2 🖾 No 24 hours after death.

Funeral Director After this certific leted filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 2 🗓 No Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending work' 1 🗌 Yes 2 🔲 No Investigation 2 \(\subseteq \text{ Accident} \) 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hor To the Fune completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Siph

State Registrar Depinder Singh MD 14300 Gallant Fox Lane Ste 124 Bowie, MD 20715

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

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10/19/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
State of Maryland / Department of Health and Mental Hygiene
Registrar

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death
Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Eileen Marie Currier Medical October 2010 6:55 a.M 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Westminster Dove House **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 1 □ M 2 🔀 F Months Days Hours (Month, Director 112-20-4882 85 2/10/1925 Vashington, DC Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Hampstead Carroll MD 1 X Yes 2 No 5 10e. Street and Number 10f. Zip Code 21074 10g. Citizen of What Country? Funeral 1211 N. Main St. Apt 400 USA Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. white Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Specify th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Craft designer 12 Craft World Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lloyd Currier Kathleen Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JoAnn Kathleen Turner, daughter 623 Amana Drive, Brandon, FL. 33510 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any injury or or 1 Durial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 10/19/2010 | Hampstead, Md. Signature of Funeral Service Licensee M00741 22. Name and Address of Facility Eline Funeral Home our emmer 934 S. Main Street, Hampstead, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) PULMONART ADPIRATION Medical Due to (or as a consequence of): **Examiner** E SOPHAGEAL DISMOTILI Sequentially list conditions. Examine cause. Enter Underlying Cause (Disease or iinjury CERTIFICATION APPROVED BY MEDICAL EXAMINER burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Completed by Physician/Medical Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) Live Birth 2 Fetal dea Pregnant at time of death for in the past 12 months?
1 Yes 2 No Month ed by the a detached f 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available page 2 autopsy prior to completion of cause of performed Yes 2 death? this certificate 1 Yes 2 40 **Division of Vital** funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ျှ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE e Hospital or Attending Ph 124 hours after death. e Funeral Director: After th 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed To the P within 2. only one 29b. Signatore and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12040 10/18/10 curloss 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21157 WASHINGTON HUS WESTERINSTER MA 245 MI HOWARD LANHAM 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State

Registrar

OCT 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Catherine Rebecca Calp 10:00% October 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Future Care Cherry Wood Baltimore Reisterstown 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year) 3/27/1928 Months Hours Country) 1 M 2 Director 217-24-8803 82 MD Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho.

ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No Reisterstown Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17 Delight Road 21136 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 XNo Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ☐ Yes 2 🔀 No Specify: Specify: white 3X Widowed 4 ☐ Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 6 homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Shadrack C. Cole Nancy R. Lloyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marilyn Howard, daughter 17 Delight Road, Reisterstown, Md. 21136 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/21/2010 permit. Page Department of Important: If any injury or Hampstead, Md. St Peter's Cem. Signature of Funeral Service Licensee 22. Name and Address of Facility Eline Funeral Home M00741 Lemmer Main Street, Hampstead, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent preg 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Day 5 Other (specify) Pregnant at time of death signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy has within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page To the Hospital or Attending Physician: 25. Was case referred to dical To Be 26. Place of Deat (Check only one) examiner? Other: 2 No 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 1 Natural 5 Pending 2 🗌 No 1 Yes Investigation ☐ Accident☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Certifying Physician: T 29a. Certifier the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Medical Exag 3 Certifying ctioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 7/2009

Registrar

29b. Signature and title of ce

31. Date filed (Month, Day, Year,

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(Item 23a) (Type, Print)

Registrar's Sig

29d. Date signed (Month, Day, Year) 18

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Month 1105 DWARD Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Annapolis 4c. County of Death Examiner Ginger Cove Anne Arundel 5. Social Security Number 476-01-9608 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 D F Days Hours 6/22/1917 Missesota **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location **Funeral Director** Annapolis Anne Arundel Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21401 6206 River Crescent Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Was Decedent 2... Armed Forces? 1

XYes 2 □ No WWII Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify White Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) USNA Professor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) မ Ida Elksner Albert Cook 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 625 Willow Knoll Dr, Marietta, GA 30067 19a. Informant's Name/Relationship (Type, Print) Jody Noland - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Baltimore Crematory 1 ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State 10/14/2010 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home Signature of Funeral Service Licensee 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and deepached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Live Birth 2 Pregnant at time of death 3 🔲 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) Yes 2 No g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should to 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗌 No 1 Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? GINGER Other: 4 Nursing Home 5 Residence မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner_of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of contifie 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) 5+ -la

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) 0CT 15 2010

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend #21 Per FH G909 11/05/10 JH.
State of Maryland / Department of Health and Mental Hygiene 0 | 0 for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month а м 2010 7:40 Linda Ann DIXON October 0 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Baltimore Towson 8. Date of Birth (Month, Day, Oct. 8 If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Months Days Hours Min Maryland Yrs. 58 Director 217-58-2742 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits rector 1 🗌 Yes 2 💢 No <u>Keedysville</u> Maryland Washington ō 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 5135 Porterstown Road 21756 items ? hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 👿 No Black, White, etc. and Mental Hygiene. is marked other than "natural", or δ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed Specify: 3 Widowed 4 Divorced White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Dispatcher Freight Hauler Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic once. Robert Marcus Harris Christina Catherine Stevenson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5135 Porterstown Road, Keedysville, Md. 21756 <u> Greg Dixon, Sr. - Husband</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 \square Burial 2 X Cremation 3 \square Removal from State 4 Donation 5 Other (Specify) Hagerstown Crematory 10/25/10 Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home Robert B. Rankin per DVR 415 E. Wilson Blvd. Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Respiratory Physician/ arest disease or condition Medical resulting in death) Due to (or as a consequence f): Examiner MUCUS PIU Sequentially list conditions, Examine If any, leading to immediate cause. Enter Underlying Due to (or as a consequence of Nasal Tumor montus Hospital or Attending Physician: The law requires that the death certificate be executed bunial-transi Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) months attending physiciar by Physician/Medical rein αu Corcinma Division of Vital Records, P.O. Box 68760 the for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No 5 Other (specify) Month Day Year Pregnant at time of death be detached the 9 Unknow signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s has performe certificate 2 🗌 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) WSglu Hospital: 1 Tyes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury After 1 Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: At 2 Accident Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) OCTUSCI 21 2010 Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles st AMIES W) SH-4 31. Date filed (Month, Day, Year) distrar's Signature State OCT 25 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DAVIDSON oct 21, 5:30 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Collington Episcopal Life Care Mitchellville Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 1 □ M 2 🖾 F 86 Ouincy Director 121-16-3175 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at. 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Mitchellville Maryland 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 10450 Lottsford Road 20721 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 X No If Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) iene. Elementary/Seconday (0-12) College (1-4 or 5+) Geologist US Geological Survey should be filed with and Mental Hygien 7 is marked other ti 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Warren A. Bates Elsa Piehler Department of Health and Men Important: If item 27 is marke any injury or other traumatic and 2 should by Health and Meretem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leslie K. Davidson / Daughter 1792 Duffield Lane, Alexandria, VA 22307 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 10/30/2010 Mount Hope Cemetery East Weymouth, MA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Rem 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between PERTENSION Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner ERLIPIDEMIA Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine YROID ISM Cause (Disease or linjury sician and burial-trans that initiated events resulting in death) Last nding physician ause as the burial-Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burn P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 X No Year Dav Pregnant at time of death signed by the aid Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 🕱 No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No nours after death, neral Director: Aff I filled in by the fur Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 5 8 0 29b. Signature and title of certifier 100mm Name and address of person who completed cause of death (Item 23a) (Type, Print) B21. Bowie, MD 20715

Registrar

31. Date filed (Month, Day, OCT 2 5 2010

SUPERIOR

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCT Month Physician/ 2010 0855 Raymond Justin DeForge Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 7. Age (In yrs. last birthday) 76 yrs If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number Funeral DC Country) 1 🛛 M 2 🗆 F Months Days Hours Min. DEC 1 Day, Year) 1933 **Director** 579-46-1986 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director Bethesda 1 Yes 2 X No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral 20817 United States items 23a 9518 Ewing Dr. within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 X Married 2 X No "natural", or ğ Yes Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Map Maker Cartographer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Mary Evelyn Garrison John Justin DeForge permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angelico Rd. NW Palmbay, FL 32907 Jennifer R. Trosis/Daughter Baltimore, 20b. Place of Disposition (Name of Atlantic Crematory, LLC 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Durial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/21/2010 Glen Burnie, MD 21. Signature of Funeral Service Licensee ²² Name and Address of Facility Thibadeau Mortuary Service, p.a. 7 Park Ave., Gaithersburg, MD 20877 M00956 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ruptured Abdominal Aortic Aneurysm Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Acute Renal Failure Sequentially list conditions, if any, reading to immediate cause. Enter Underlying 2010 Examine Due to for as a consequence of inding physician and use as the burial-transit Cause (Disease or linjury Shock due to rupture of Aneurysm that initiated events resulting in death) Last Due to (or as a consequence of): Box 6876008 October 19, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atten for u in the past 12 months?

1 Yes 2 No
9 Unknown Month Other (specify) Pregnant at time of death signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Peripheral Vascular Disease Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed eforge, Raymond 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy this certificate has page 2 perform death? Yes 2 X No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific sempleted filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 🗌 Yes 2 X No ဂ္ဂ 1 X Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: work? iniury 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗀 only one) 29c. License number 29b. Signature and title 29d. Date signed (Month, Day, Year) 10/19/10 8 JUDARSHAW SIVA D65312

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

3481

State

Registrar

8600 Old Georgetown Rd., Bethesda, MD

20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

MD

Siva

22

Sudarshan 31. Date filed (Month, Day, Year

Baltimore. Maryland 21215-0036

Division of Vital Records. P.O. Box 68760.

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Phys this	<u>د</u>	1 ☐ Yes 2 27. Manner of Deat	No	Hospital: 1 28a. Date	Inpatient 2	ER/Outpatie	III 3 L DOA		□ Nursing H				cityRESIDENCE
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Sta	te	31. Date filed (Mon	nth, Day, Year)	32/F	Registrar's Sign	nature	,, ,	,	01 (1	us ivil,		0100	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 12, 2010 7:03 PM Daitnarayan Dwarka Medical 4a. Facility Name (if not institution, give street and number) 4b City Town or Location of Death 4c. County of Death **Examiner** Prince George's 4806 Bartletts Vision Drive Bowie Date of bit... (Month, Day, Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 € M 2 □ F Months Days Hours Min. Yrs **Director** Guyana 219-19-1926 August Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 🗌 Yes 2 🙀 No Prince Georges Maryland Bowie 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 4806 Bartletts Vision Drive 20720 IISA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 5 þ 1 Never Married 2 😾 Married 1 ☐ Yes 2 ☐ No 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 👿 No Specify: Specify: Fast Indian "natural", 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Rice Industry Farmer Be 17. Father's Name (First, Middle, Last) UNK 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H

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traumatic ever of Health and Mental of Health and Mental မ Dwarka Ramdai 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4806 Bartletts Vision Drive, Bowie, Maryland 20720 Hymranie Daitnarayan - Wife other t 20a. Method of Disposition Department of H Important: If itel any injury or oth 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Washington Crem. 10/17/2010 Laurel, Maryland 21. Signature of Funeral Service Lie 22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707 MD1283 23a. Part 1. Enter the dilease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ STROKE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Oxtenol Clisease Penpheral Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: signed by the attending be detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 2 No 1 L Yes 2 L 9 D Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by uobelės 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Hyperlansian 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐ Yes 2 ☐ No Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 1 No al or Attending Physics after death. I Director: After this or ဂ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Reverder MD 20737 Die Rluto 2400 6510, Kenilwostn REVA GILL 31. Date filed (Month, Da 32. Registrar's Signature State OCT 192010

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER 17. 2010 MADINE MAVIS PANKEY de CAPITEAU 11:45 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ginger Cove Health Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Months | Davs | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 9/30/1909 Missouri 101 278-52-5915 Director Usual Residence of Decedent 28a-f show 10b. County 10c, City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland 10a State Examiner must be notified at Director 1 Yes 2 X No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? ò Funeral items 23a USA 21401 4000 River Crescent Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 1 Never Married 2 Married "natural", or Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates 3 X Widowed 4 □ Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Speech and Hearing 2 years Therapist other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be fill. Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve 2 Hallie Hallenberg Rilev R. Pankev 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Buffalo Bur Rd., Silver City, NM 88022 Theodore de Capiteau/ Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 K Removal from State Rose Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 10/20/10 Brookfield, MO 22. Name and Address of Facility GEORGE P. KALAS FUNERAL HOME . Signature of Funeral Berville Licensee 2973 SOLOMONS ISLAND ROAD, EDGEWATER, MD. 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Jeath Immediate Cause (Final Physician/ disease or condition Medical resulting in death) (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 Yes 2 No 9 Unknown Month Day ate has been signed by the page 2 should be detached Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a Wasan autopsy performed certificate has completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Be 2/10 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes မ within 24 hours after death. To the Funeral Director: After this 27. Manner of Death 1 Natural 2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: To the Hospital or Attending 5 Pending 1 Yes 2 No Accident Sulcide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and the of certifie

State Registrar 31. Date filed (Month, Day, Year

au

of person who completed cause of

= Defense Hwy

death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical 10 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Brooke Grove Rehab & Nursing Center Sandy Springs Montgomery 8. Date of Birth (Month, Day,) June 15 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗶 F Months Washington. Director 577-34-1667 1928 Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Completed by Funeral Director 1 Tes 2 X No Maruland Silver Spring Montgomery 10e. Street and Number 10g. Citizen of What Country? 15100 Interlachen Drive, #607 20906 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give 3 Widowed 4 Divorced Caucasian Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Felix Paravati Mary Catherine Cinotti and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Philip Elmendorf-Son 305 Myers Manor Court. Silver Spring. MD 20905 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/23/2010 | Silver Spring, MD Gate of Heaven Cem. 21. Signature of Fungral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home. 11800 New Hampshire Ave., Silver Spring, MD 20904 Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or linjury Due to (or as a consequence of): that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s Hospital or Attending Physician: The performed' 2 🗌 No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 1 Yes 2 140 ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral 1 Natural 5 \square Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 57630 en his 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

Records, P.O.

Division of Vital

Anuradha Arun, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 34820 Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month OCTOBER RO.Y LEE ELLIS 20106:00 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S 5703 LYNGATE COURT LANHAM 5. Social Security Number If Under 1 Year 6. Sex If Under 24 Hrs. 8. Date of Birth (Month, Day, JUNE 25 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral Days Min. 1 XM 2 F Hours WILSON, NC 578-56-6720 69 Director Yrs. Usual Residence of Decedent or 28a-f shov 10a State 10b. County filed within 72 hours after death with the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director notified 1 🛚 Yes 2 🗆 No MD PRINCE GEORGE'S LANHAM 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Examiner must be items 23a Funeral 5703 LYNGATE COURT 20706 USA 1. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 9 Š 1 Never Married 2 XMarried XYes 2 No ARMY Baltimore, Maryland 21215-0036 1 Tes 2 X No Specify: BLACK Specify: "natural" Completed 3 Widowed 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 i e witnent of Health and Mental Hygiene. Impor ant; If feen 27 is marked other than "na any injury or other traumatic event". (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) MACHINIST PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ COLEY LEE ELLIS ANNIE LEE WOOD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5703 LYNGATE COURT LANHAM, MARYLAND HELEN ELLIS/WIFE 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Donation 5 ☐ Other (Specify) NATIONAL CEMETERY: 10-22-2010 LAUREL, MARYLAND ure of Furnal Service Signa J.B. JENKINS FUNERAL HOME, INC. 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final LUNG CARCINOMA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 [Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1X Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed page 2 💢 No Yes 2 **X**No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 X Yes 2 □ No Hospital Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 28c. Injury at work? 27. Manner of Death Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) XNatural Accider injury 5 Pendina 2 No M 1 Yes Accident Investigation after death 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier 🚨 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Hospital or Attending Physician: The law requires that the death certificate be executed Records, P.O. Box 68760 Division of Vital completed filled in by Medical (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only on 3 Certifying Nurse/Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) D32261 OCTOBER 14, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8116 GOODLUCK ROAD # 300 LANHAM, MARYLAND 20706 RICHARD FELDMAN M.D 32. Registrar's State Registrar DHMH 17 Rev 7/2009 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 3482 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Roy Farrell 5:39 AM Medical 0 Eacility Name (if not institution, give street and nu Examiner 4b. City, Town, or Location of Death 4c. County of Death 5a 5 11 COMICO **Funeral** Age (In vrs. 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) New Jersey 1 **X** M 2 □ F 03/06/1919 220-09-1433 91 Months Hours Min Director Usual Residence of Decedent or 28a-f shov 10a, State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Wicomico 1 Yes 2 No Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 748 South Park Drive Funeral "natural", or items 23a 21804 USA death v 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Marine Year or Dates. Corp Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 hours after 1 ☐ Yes 2 🗷 No Specify: Completed 3 X Widowed 4 Divorced Specify: white 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry within 72 (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) linesman electrical permit. Page 1 and 2 should be filed in Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roy Farrell Mary Shockley 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6390 Collins Rd., Parsonsburg, MD 21849 Claudette Vincent/daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Parsons Cemetery 1 X Burial 2 Cremation 3 Removal from State 10/20/2010 Salisbury, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses Adlroway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 ata 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on such line. Interval Between Immediate Cause (Final Onset and Death Physician disease or condition are Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) sician and burial-transit Due to (or as a consequence of) resulting in death) Last within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician recompleted filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 🔀 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 🔀 No Other: 4 Nursing Home 5 Residence 6 K Other (Specify) 1 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpa 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending injury Investigation
6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Z Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 29505 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

GREGORIO

31. Date filed (Month, Day, Year)

5302 CHINABERRY DR.; SALISBURY, MD 21801

LOSO;

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#1perpHYS, G909, 11/17/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last)
Georgianna Harps Foddrell
Georgianna Harps Foddrell 2. Date of Death 3. Time of Death Physician/ 2010 Day Month Oct 6, 19:50 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours North Carolina Feb15, 1938 Director 243 54 4954 72 Yrs. Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified Maryland Prince George's 1 🗆 Yes 2 💹 No Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7410 Oxon Hill Road 20745 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent Armed Forces?

1 Yes 2 XXNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 9 Completed by 1 Never Married 2 Married If Yes, Give Year or Dates. 1 ☐ Yes 2XX No Specify. "natural" 3 Widowed 4 X Divorced Specify. Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) Security Fedx Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked of traumatic ever ည Adam Harps Jonell Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Helen Greene 7410 Oxon Hill Road, Oxon Hill, MD 20745 (sister) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State Department of Important: If it any injury or c 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Guilford Memorial Park 10-13-2010 High Point, North Carolina 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Signature of Juneral Service Lic Ferry Road, Clinton, MD 20735 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due! Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events (or as a consequence of burial-transit and resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical the be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 3 Probably 4 Unknown 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s autops Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending Natural 5 Pending iniury work? 2 No Accident Suicide Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29d. Date signed (Month, Day, Year) ompleted cause of death (Item 23a) (Type, Print) 7503 waits Ton, MD State Registrar

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		,	for State Registrar		State of M	arylan		rtment tificate			lental Hy	giene Reg. No	2010	34823	
	Physicia	ın/	Decedent's Name (First,	,	t)						2. Date of De Month	ath Da	ay Year	3. Time of Death	
	Medio Examir											r 19	2010 County of Death	6:45 A M	
-			Client Hospi	ent Hospice Center Mt. Airy									Frederic	k	
ŀ	Funeral Director		212-24-2846		-X	e (In yrs. la	st birthday) Yrs.	If Under 1 Months [ays Hou	nder 24 Hrs. Irs Min.	8. Date of Bir (Month, Da 4/19/1	th y Year) 912	9. Birth Co <i>u</i> i	place (State or Foreign htry) MD	
	and show	Į.	Usual Residence of Deceder 10a. State 10b. C			10c. City, Town or Location								10d. Inside City Limits	
	Mary 28a-f	Director		rroll		Wes	stmins						1 ☐ Yes 2X No		
	with the 23a or		10e. Street and Number 1560 Friding	er Mil	ll Road		10f. Zip Code 21157					10g. Citizen of What Country? U.S.A.			
9	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status		12. Was Decedent B Armed Forces? 1 Yes 2) If	/as Deceden Yes, specify	of Hispanic Cuban, Mex	kican, Puerto F	cify Yes or No- Rican, etc.)		14. Race - Americ Black, White,		
00	ours at atural" cal Exa	eted	3 X Widowed 4 □ Div	orced ecedent's Ed	If Yes, Give Year or Dates.		1 ☐ Yes 2 🔀 No Specify:						Specify: Whi		
Maryland 21215-0036	nin 72 h ne. :han "n i e Medi	Completed	(Specify only Elementary/Seconday (C	highest gra	College (1-4 or 5	5+)	(Give k		one durina i	most of workin	g	16b. Kind of Business Industry			
d 2	led wit Hygien other i ent, th	Be	7 17. Father's Name (First, Mi	ddle, Last)			Hor	nemake		Nother's Name	(First, Middle,		n Home Surname)		
ylan	ild be fi Menta narked atic ev	မ	Noah Arba	ugh						Ivy Co	ppersm	ith			
Mar	12 shou alth and 27 is rr r traurr		19a. Informant's Name/Rela								Route Numbers Mill:		ity or Town, State, Zip Code) MD 21117		
Baltimore,	ge 1 and nt of Hea : If item or othe		20a. Method of Disposition	ation 3 🗆	Removal from State		lace of Dispos emetery, crem	ition (Name	of	 	ate	<u> </u>	ocation - City or Ti	own, State	
altin	permit. Pa Departme Important any injury once.		4 ☐ Donation 5 ☐ 0 21. Signature of Funeral Se			Mea		ranch Name and A					minster, al Home 8	MD Chapel, PA	
<u> </u>			Many 10		lications that course	I the death				on Road	, West	mins	ster, MD	21157	
	Enysician/ Medical Examiner	6 10												Interval Between	
	uted d ansit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events		Due to (or as a	a consequ	ence of):			-					
0	icate be executed physician and s the burial-transit	edical Ex	resulting in death) Last	L	Due to (or as a	a consequi	ence of);								
68760	ertificate ding ph	/Мес	IF FEMALE:		23c. If yes, outcome of pregnancy										
Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnar in the past 12 months? 1 Yes 2 No 9 Unknown	Ectopic pregnancy Other (specify)				23d. Date of delivery Month Day Year							
ds, P.C	uires that in signed build be deta	by	Part II. Other significant co				tobacco use contribute to the cause of death? Yes 2**MNo 3 □ Probably 4 □ Unknown								
Division of Vital Records, P.O.	The law required the law reconstruction and the law beep and a should be sho	Completed	Mixed Hyperlipidemia									utopsy prior to completion of cause of death?			
ta	ding Physician: The lath. th. After this certificate hattuneral director, page	Be	25. Was case referred to me examiner?	-	lospital:			2	Other:	Death (Check	only one)	1		/v -	
of <	ig Physiter this or neral dii	te: To	1 Yes 2 No 27. Manner of Death		1 ☐ Inpatie 28a. Date of injur (Month, Day	у [ER/Outpatient 28b. Time of injury	28c.	4 ∟ Injury at		ne 5 Resid		Other (Specify y occurred	Horpice	
sion	vttendir death. ctor: Af y the fu	Certificate:	2 Accident In 3 Suicide 6 0	ending vestigation ould not be				М	work? 1 Yes 2		Of Leastine /C	tmat an	d Number or Rural	Dougla Mumban	
D	ital or furs after ral Dire			etermined	building, etc	. (Specify)					City or Tow	n, State))		
	he Hosp in 24 ho he Fune	Medical	(Check 2 □ Med	ical Examin	ician: To the best of oner: On the basis of exercioner: To the l	camination	and/or investig	ation, in my	pinion, deat	h occurred at t	ne time, date ar	nd place.	and due to the cal	use(s) and manner stated.	
	WIL ST		29b. Signature and title of ce	edifier Euro	Tece; of)		29c. Lie	ense numb	er		29d. Dat	te signed (Month,	Day, Year)	
	7		30. Name and address of pe	rson who co	ompleted cause of de	eath (Item 2			7 2	10 D==	J 17	<i>t</i>	11 MD 1	21074	
	Stat	e	Deogracias F 31. Date filed (Month, Day, Y	ear)	32. Redistra			RECKTE	ysvli	те козо	d, Hamp	stea	au, MD .	21074	
	Registra	ır	OCT	192	010 Dener	مساسان	A. 1	arkel							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - State Registrar		partment of Health a ertificate of Death		iene Reg. No.2010	34824	
Physic		1. Decedent's Name (First, Middle, Last) Helen Marie	Friedman		2. Date of Deat Month October		3. Time of Death 1:15 p M	
Med Exam		4a. Facility Name (if not institution, give street and 911 Russell Avenue	number)	4b. City, Town, or Location of	f Death	4c. County of Deat	h .	
Funera		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday	Gaithersburg () If Under 1 Year If Under 2 Months Days Hours	24 Hrs. 8. Date of Birth	Mon tgomers 9. Bir	hplace (State or Foreign	
Directo		Usual Residence of Decedent	86 Yrs.		Min. (Month, Day, June 30,	1924	unitry) DC	
Maryland 28a-f sho otified at	Director	10a. State 10b. County 10b Howard	10c. City, Town or I	Location Cooksville			10d. Inside City Limits 1 ☐ Yes 2 🌁 No	
h with the ns 23a or	Funeral D	10e. Street and Number 14611 Riggs Meadow Drive		10f. Zip Code 21723		10g. Citizen of What Co USA	untry?	
Baltimore, Maryland 21215-0036 Jennit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ted by Fur	1 Never Married 2 Married 1 1 If Yes,	/es 2.2MNo	8. Was Decedent of Hispanic Origing If Yes, specify Cuban, Mexican, 1 Yes 2 No Specify:	in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ame Black, White Specify: Whit	e, etc.	
1215-(thin 72 hou sne. than "nat the Medica	Completed	15. Decedent's Education (Specify only highest grade comple Elementary/Seconday (0-12) Colleg	ted) (Giv e (1-4 or 5+) (life.	edent's Usual Occupation re kind of work done during most DO NOT use retired)	of working	16b. Kind of Business	Industry	
land 2 be filed wi ental Hygic ked other ic event, ti	To Be (17. Father's Name (First, Middle, Last) Daniel Francis Scanlon	FIC		r's Name (First, Middle, N en Vivian Malc			
Baltimore, Maryland 21215-0036 Mitt. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinance.		19a. Informant's Name/Relationship (Type, Print) Michael L. Friedman/Son	19b. Ma	iling Address (Street and Number	or Rural Route Number,	City or Town, State, Zip	Code)	
imore, Page 1 and nent of Her and: If item		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal f 4 □ Donation 5 □ Other (Specify)			Date Oct. 23 2010	20c. Location - City or		
Balt permit, Depart Imports any inji		21. Sign for of Funeral Service Licensee		22. Name and Address of Facility Francis J. Collins 500 University Blv	Funeral Home	Inc.	-	
Pnysician Medica			n each line. cardial Infarction		ardiac or respiratory arre	st,	Approximate Interval Between Onset and Death 30 mins	
Examine	1	Sequentially list conditions, b.	to (or as a consequence of): to (or as a consequence of):					
ecuted and I-transit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events c.	to (or as a consequence of):					
68760 certificate be executed nding physician and use as the burial-transit	edical	d						
P.O. Box 687 that the death certifics ned by the attending p e detached for use as t	Physician/M	in the past 12 months? 1 □ L 1 □ Yes 2 😿 No 4 □ F		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of del Month	very Day Year	
IS, P.O	þ	Part II. Other significant conditions contributing Metastatic Breast Cancer	pacco use contribute to	the cause of death?				
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attencompleted filled in by the funeral director, page 2 should be detached for the completed filled in by the funeral director, page 2.	Completed				24a. Was ar autops perforn 1 Yes 2	y prior to d	opsy findings available ompletion of cause of	
/ital rsician: rsician: rsician:	To Be C	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	☐ Inpatient 2 ☐ ER/Outpati	26. Place of Death				
n of \ ding Phy th. After this funeral c		27. Manner of Death 28a. D. 1 Natural 5 ☐ Pending	ate of injury fonth, Day, Year) 28b. Time injury		28d. Describe ho		<u></u>	
JIVISIO al or Atten a after dea Director: d in by the	Certificate:	3 Suicide 6 Could not be	ace of Injury - At home, farm, s illding, etc. (Specify)			Street and Number or Rural Route Number, vn, State)		
he Hospit: in 24 hours he Funeral pleted fille	Medical	(Check 2 \(\sum \) Medical Examiner: On the	basis of examination and/or inve	n occured at the time, date and plestigation, in my opinion, death occured at the time, date a	urred at the time, date and	d place, and due to the c	ause(s) and manner stated.	
Pot to the company of		29b. Signature and title of certifier	Swit is	29c. License number D192		9d. Date signed (Month October 19,	**	
,		30. Name and addess of person who completed of John Me/nick, MD 911 Rus	. , , , , , ,	Print) hersburg, MD 20877	,			
Sta Registi		31. Date filed (Month, Day, Year) OCT 21 2010	Registrar's Signature	N. J.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34825 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10/18/2010 ROY GEORGE FOSTER Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 02/03/1928 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 XM 2 □ F Country)
Januaica Hours Director ukn 82 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director MD Montgomery Silver Spring 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 13009 Autumn Drive 20904 Jamaica 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🎛 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status ρ Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 2 should be filed with h and Mental Hygien 7 is marked other th 6th Stone Cutter Masonry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Downer Foster Beatrice Gibson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Beverly Foster-Okoro - daughter 13009 Autumn Drive, Silver Spring, MD 20904 200. Place of Disposition (Name of cemeter) crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 X Buria 2 Cremation 3 Removal from S 4 Donation 5 Other (Specify) Resthaven Cemetery 10/28/10 Hagerstown, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 Part 1. Enter the disease, or conshock, or heart failure List only ications that caused the death. ne cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the diseas Interval Between Immediate Cause (Final Onset and Death Physician/ Metastatic/Prostate Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-transit that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Day 5 Other (specify) the P.O. þ 23e. Did tobacco use contribute to the cause of death? signed to d be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. Completed by Records, 1 Yes 2 No 3 Probably 4 X Unknown Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 X No To the Hospital or Attending Physician: (within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, t Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 XNo 1 Inpatient 2X ER/Outpatient 3 IDOA ည 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D35112 10/18/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul B. Baker 1500 Forest Glen Road, Silver Spring, MD 20910 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No-1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 17, John M. Firth, Jr. 2010 2:30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Mitchellville Collington Episcopal Life Care 8. Date of Birth Nov 25 If Under 1 Year If Under 24 Hrs. . Social Security Number 6. Sex 1 X M 2 🗆 9. Birthplace (State or Foreign **Funeral** Months Hours , 1910 Pennsylvania 99 Director 068-03-6832 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 X Yes 2 No Montgomery Chevy Chase <u>Maryland l</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20815 8206 Ellingson Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 ₩ Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sperry Corporation Machinist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Minnie Williams John Mirkil Firth, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8206 Ellingson Drive Chevy Chase, MD 20815 <u>Isabella Firth/ Granddaughter</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Baltimore Washington 10/19/2010 Laurel, MD 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 2 Weeks Immediate Cause (Final Physician/ Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Illijury Due to (or as a consequence of) Exami anding physician and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Coronary Artery Disease 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Chronic Kidney Disease has autopsy performed? Yes 2 No page 2 1 Yes 2 No Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) Hospital 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 🗌 Yes 2 🗆 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurge Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number D47603 m who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

William DuBoyce, M.D.

12158 Central Avenue Mitchellville, MD 20721

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 34827 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 2010 10:40 AM Michael T. Flanagan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 1496 Manor View Road Davidsonville 6. Sex 1 XM 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Numbe 215-78-8763 **Funeral** Washington.D.C Director 50 Usual Residence of Decedent or 28a-f show s notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director Davidsonville 1 🗆 Yes 2 🔀 No Maryland Anne Arundel ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 21035 United States 1496 Manor View Road items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status an "natural", or iter Medical Examiner Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 Divorced 1978-83 White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) alth and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Machine Shop/Glasswork Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Gladys Robey Daniel J. Flanagan, Jr. 1 and 2 should be of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gladys Flanagan/Mother 1496 Manor View Road, Davidsonville, Maryland 21035 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or of once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Memorial Gardens 10/21/2010 Davidsonville, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signatu ervice Licensee 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition UF THE LARLYNIX CELL CAYGER -Physician/ > QU Amous Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of, ng physician and as the burial-transit or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Year Day Pregnant at time of death detached Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) To Be Hospital 1 Tes 2 No Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No М Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined To the Hospital Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, ueau occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cortifie 29d. Date signed (Month, Day, Year) 463632 010

Registrar

State

Drive.

Ste.

128. Glen Burnie.

808 Landmark

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Samuel Kumah

Date filed (Month, Day, Year)

For State Registrar	
---------------------------	--

Certificate of Death

	Physician
	/Medical
•	Examiner

Funeral Director

ed other than "natural", or items 23a or 28a-f show event, the Wedical Exeminer must be notified at marked other Tis mark permit. Pages 1 and 2 st Department of Health an Important: If Item 27 is r any injury or other traur

72 hours after death

Saltimore, Maryland 21215-0036

Box 68760.

P.O.

Division of Vital Records,

Physician /Medical Examiner

death certificate be executed sician and burial-trans attending physician for use as the buria ned by the a has Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificately filled in by the funeral director, p

within 24 hours a To the Funeral L

2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 9:29 Рм 10/10/2010 William Fleming Gaghan 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Washington Adventist Hospital Takoma Park Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Days Hours 1 XX M 2 □ F 63 213-56-0234 July 6, 1947 Washington, DC Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location Director 1 XYes 2 No Hyattsville Prince George's Maryland 10g. Citizen of What Country? 10e, Street and Number 20781 USA 5805 42nd Avenue, Apt.#309 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 XYes 2 No 1 Never Married 2 ☐ Married If Yes, Give Year or Dates: 1972–1974 1 ☐Yes 2 No Specify: Specify: White 2 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Smithsonian Institution Guard 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nicholas Longworth Gaghan Sarah Agnes Robinson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 309 Willow Run Ct., Millersville, MD 21108 Catherine L. Bowman / Aunt Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metropolitan Crematory 10/18/2010 Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4739 Baltimore Avenue Lanning Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final WIE MYOCARDIAL INFARCTION disease or condition resulting in death) Due to (or as a consequence of): CORONARY ARTERY if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 1 Yes 2 No 3 Probably 4 Unknown DIABETES Completed FAILURE 24b. Were autopsy findings available prior to completion of cause of death? HUTRI CONGESTIVE 24a. Was an autopsy performed HYPERTENSION 1 ☐ Yes 2 ☐ No 1 □Yes 2 ■No 25. Was case referred to medica 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier JOS PLE OCTOBER 11, 2010 D40324 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYLAND PARK, AVENUE TAKONA TERRY JOD RIE, MO, FACED 7600 CARROLL 31. Date filed (Month, Day, Year) State OCT 2 5 2010 Registrar

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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Fune		rried 21 Married	Arm 1 5	ned Forces? Yes 2⊟ es Give	NoWorld		Was Deced f Yes, spec 1 ☐ Yes 2		spanic Ori in, Mexicar Specify:		cify Yes or No Rican, etc.)	0-	Black	- Americ k, White, Whi		
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Division	I or Atten after death Director: I in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not determine		Place of injusting building, et	ury - At home, c. (Specify)	, farm, str	eet, factory	, office		2	28f. Location (City or To	(Street a wn, Stat	nd Numbe e)	er or Rura	l Route Number,	
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	To the Hospital or Attenwithin 24 hours after death to the Funeral Director: Completely filled in by the	Medical	(Check only one)	2 Medical Ex	aminer: On	the basis of manner st	f examination	and/or in	vestigation,	in my or	pinion, dea	ath occurr	ed at the time	, date ar	nd place, a	and due to	the cause(s)	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 6:20ам 2010 William T. Gray Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Friends Nursing Home Montgomery Sandy Spring Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Country) Maryland 1 **X** M 2 □ F Hours (Month, Day, Year) 10/02/1912 98 Director 214-03-8712 Usual Residence of Decedent or 28a-f shov Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must ha marified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring 1 Yes 2 No Maruland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 812 Notley Road 20904 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: 3 X Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sanitation Engineer 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ William Theodore Gray Rose Bowman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27099 Ecuador Drive, Punta Gorda, Florida 33983 Marie Gabrielsen - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 🛭 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Norbeck Memorial Park 10/22/2010 Olney, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, MO 1800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Arterial Sclerotic Disease <u>Years</u> disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) signed by the attending physician and detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Pregnant at time of death 5 Other (specify) 9 Unknown 1 ☐ Yes ∠ ☐ q ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Diabetes Mellitus 1 ☐ Yes 2 🗶 No 3 ☐ Probably 4 ☐ Unknown been a 24b. Were autopsy findings available Dementia 24a, Was an prior to completion of cause of death? has performed 2 🗆 No Yes 2 X No 1 Yes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital: 2 🛛 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending X Natural 1 Tes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after To the Hospital within 24 hours a To the Funeral C Medical 29a Certifie 1 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: The basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: The best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ce October 21, 2010 D08381 who completed cause of death (Item 23a) (Type, Print)

State Registrar 18111 Prince Philip Drive, Suite T-14, Olney, MD 20832

M.D.,

Benjamin Aurunin.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Physician/ 13 AM ORA GONWIN TOB JOIC Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MON TGOMER HOSPITA TAKOMA PMR ADVEN TIS MATHINATON Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday Funeral 05/28/192 1 □ M 2 F Days Hours Months 577-76-3185 83 MD Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a. State 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No MD Prince George's Hyattsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 20782 6000 Sargent Road, #203 should be filed within 72 hours after death and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12 Was Decedent Ever in U.S. Armed Forces? Black, White, etc. à 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Ruben Dove Florence Hogan permit. Page 1 and 2 should Department of Health and Mi Important: If item 27 is mar any injury or other traumati once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6000 Sargent Road, #203, Hyattsville, MD 20782 James Godwin - husband 20a. Method of Disposition Disposition (Name of crematory or other place) 20c. Location - City or Town, State 20b. Plac 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State of Heaven Cem. 10/23/2010 Silver Spring, MD 4 Donation 5 Other (Specify) Gat 22. Name and Address of Facility Snowden Funeral Home 21, Signature of Funeral Service Licenses 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease or complication o not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one se on each line Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated overtex.) Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ON RENAL DISCATE 2 No 3 Probably 4 X Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \sum Nursing Home 5 \sum Residence 6 \sum Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 2010 05 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carrol Avenue , Talcoma Park, MO TG 00 31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 18 Month Bernice Lois Greer 2010 1548 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8103 River Gate Lane Prince Georges Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, 02 16 1 □ M 2**X**□ F Months Hours Min. Country) Director 84 049-20-3085 Usual Residence of Decedent 28a-f shov 10a. State 10c, City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Directo 1 ⋤ Yes 2 🗌 No MD Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8103 River Gate Lane 20715 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. ģ 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates. Specify: "natural", 3 Widowed 4 Divorced Completed Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Special Agent Federal other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence Hermen Smoot Blanche Olive Bacote 1 and 2 should of Health and N item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8103 River Gate Lane Bowie, MD 20715 Lorenza Ray Greer/ Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Page 1 a Department of H Important: If ite any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery | 10/25/2010 | Brentwood, MD 4 Donation 5 Donation Other (Specify) 22. Name and Address of Facility Ft. Lincoln Funeral Home al Şervice 🕍 4301 Bladensburg Rd. Brentwood, MD 20722 23a. Part 1. Enter the disease, or co shock, or heart failure. List only mplications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each loc. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Atherosclerotic Vascular Disorder yrs. Medical resulting in death) Due to (or as a consequence of): **Examiner** Coronary Artery Disease 5 yrs. Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and tran Due to (or as a consequence of) attending physician a for use as the burial-Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the aid be detached to 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of this certificate has autopsy page 2 performed? Yes 24 No death? 1 ☐ Yes 2 🗓 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 X No 1 Tes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No neral Director: A Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined hours Funeral Medical 29a. Certifier 1 🚨 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F only one 29b. Signature d title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0058213 muno 10/21/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12150 Annapolis Rd. Glenn <u>Dale, MD</u> Farhad Jamali, MD 20769 31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2010 12:00PM FRANCES GRAY October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Prince George's Hospital Center Cheverly If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Social Security Number **Funeral** (Month, Day, Y 1 □ M 2 👽 F Days Hours Yrs. Virginia Director 228-26-8809 Jan. Usual Residence of Decedent ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 X Yes 2 No MD Prince Georges Hvattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1508 Jutewood Avenue 20785 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No Specify: Page 1 and 2 should be filed within 72 hours aft ment of Health and Mental Hygiene. Fant: If item 27 is marked other than "natural", lury or other traumatic event, the Medical Exal lury or other traumatic event, the Medical Exal 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) U.S. Government Clerk Be 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) ပ Linwood Nelson Carrie Noel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Isaiah Gray/Husband 1508 Jutewood Ave., Hyattsville, MD 20785 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition permit. Page 1 Department of Important: If it any Injury or o 1 X Burial 2 Cremation 3 Removal from State 10/23/10|Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Greene Funeral Home 21. Signature of Funeral Service License elm Franklin St., Alexandria, 22314 23a, Part 1, Enter the disease, or complications shock, or heart failure. List only one cause Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate Examiner consequence of: cause. Enter Underlying Cause (Disease or iiniury and use as the burial-trar that initiated events resulting in death) Last a consequence of physician Physician/Medical The law requires that the death certificate be Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? O Month Day Year Pregnant at time of death detached the Unknown 9 Unknow P.O. ģ th-but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributions 23e. Did tobacco use contribute to the cause of death? sate has been signed page 2 should be det δ 1 Yes 2 No 3 Probably Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes **Division of Vital** or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 2 Other: 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ Date of injury 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury 1 Natural 2 Accident 5 Pendina 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29b. Signature and 29c. License number 29d. Date signed (Month, Day

Registrar
DHMH 17 Rev 7/2009

State

of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 21, 2010 James Kaiser Hancock 5:30 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 15901 Sharpersville Road Prince George Waldorf If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🔀 M 2 🗆 F Months Days Hours June 5, 1914 216-44-3736 Director 96 Marvland Usual Residence of Decedent or 28a-f shown notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🔀 No Waldorf Maryland Prince George 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a once. Funeral 15901 Sharpersville Road 20601 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Propellant Handler U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Budd Andrew Hancock Mary Elizabeth Cooksey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fred K. Hancock 16301 Sharpersville Rd., Waldorf, Md. 20601 son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)Oct . 25, Data 2010 20a. Method of Disposition 20c. Location - City or Town, State 1 Marial 2 ☐ Cremation 3 ☐ Removal from State Waldorf, Maryland 4 Donation 5 Other (Specify) Trinity Memorial Gardens 21. Signature of Funeral Service Lice 22. Name and Address of Facility Williams Funeral Home, 4270 Hawthorne Rd., In M00668 Indian Head, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Coronary Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death signed by the al a | Unknown Unknown Division of Vital Records, P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by vous turar 1 🗌 Yes 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate has ral director, page 2 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Hospital: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 To the F only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0052999 W all MD20735

Registrar DHMH 17 Rev 7/2009

State

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31. Date filed (Month, Day, Year)

aB 10

0403

32. Registrar's Signature

Hospital Drive G-06 CLINTON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAHIMIANSMD

OCT 21

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			ForState	State of Ma	aryland		epartmer <i>Certificat</i>			d Mental I			348	JJ
			Registrar 1. Decedent's Name (First, Middle, Las	st)			or unoat		Julii	2. Date o			3. Time of I	Death
	Physicia Medic	al	Kathy Ho	1+			1			O CT	44)ay_2_2 Yea		25M
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	Funeral Director		5. Social Security Number 6. S		e (In yrs. las	st birthda Yr:	Months	r 1 Year Days	If Under 24 I Hours N	Hrs. 8. Date of Month April	f Birth , <i>Day</i> , Year	9. E	Birthplace (State or Country)	Foreign
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	nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland artiment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at e.	Funeral D	10e. Street and Number 1734 Edgewood Hil	ls Apt 103	3		10f. Zip	2174(0			S.A.	Country?	
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Baltimore, Maryland 21215-0036	urs afte :ural", o	ted b	3 Widowed 4 Divorced	If Yes, Give Year or Dates.			1 Tes	2 🔀 No	Specify:			Specify:	white 	
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aryl	hould hand Me is marl		19a. Informant's Name/Relationship (7)	ype, Print)		19b. N	Mailing Address	s (Street a	and Number or	r Rural Route Nu	mber, City	or Town, State,	Zip Code)	
Σ,	ind 2 s lealth a m 27 i		Robert W. Holt -	husband ———————					Hills				, Maryla	nd 1740
nore	age 1 a ant of H		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specia		ce	metery,	isposition (Nar crematory or c Lven Ce	other plac	e) 00	ctober 2		Location - City	orTown,State	nđ
altir	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other	1	21. Sign dure of Funeral Service Licent	7-1	T.C.D		22. Name ar					neral H		
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Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 burnsr after death certificate has been signed by the attending physici To the Euneral Director After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Certificate:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injubulding, etc			, street, factor	y, office			on (Street a Town, Sta		Rural Route Numbe	r,
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	the Hothin 24 the Fu	Mec	only one) 3 Deertifying Nur	iner: On the basis of e se Practioner: To the			ge, death occu	rred at the	e time, date an		to the caus	e(s) and manner	as stated.	ner stated.
	5 <u>№</u> 6		29b. Signature and title of certifier	10			1	. License	number 538	320	29d. [Date signed (Mo	$\sim 22.2c$	010
	1 11 2		30. Name and address of person who	completed cause of d	eath (Item :		oe, Print)				1	22 /	B	altimore
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1605 Oct HAROLD LEOMARD Medical 2010 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Rehab ma i comico 8. Date of Birth 9 Birthplace (State or Foreign Funeral 1 M 2 D F Months Hours Min **Director** Usual Residence of Decedent or 28a-f show 10a, State 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No WICOMICC 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 21814 USA Marylahd 21215-0036 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: If Yes, Give Specify: WHITE "natural", 3 Widowed 4 □ Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secon day (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 MIL TARRIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 Deer'S HEATH BLUTH HOUOWAS Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of I Important: If it 1 Durial 2 Cremation 3 Removal from State cemetery, crematory or other place, 10-22-2010 4 Donation 5 Other (Specify) ivawe mo 21. Signature of Funeral Service Licenses 23a. Part 1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician 10> Medical Due to (or as a consequence of) Examiner 07 oan n Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant a 5 Other (specify) Month Day Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| 1 Yes 2 No 3 Probably 4 Unknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has funeral director, page 2.9 performed 2 🗌 No 1 Tyes Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 - No Other: ြု 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 □ Yes 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident 2 🗌 No after death Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined e Funeral I Medical 29a. Certifier decritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gentifying Number Frantianer: To the best of my investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2. anty and) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21804

Registrar

DHMH 17 Rev 7/2009

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egistrar's Signat

10-08072 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Penny Leigh Jones 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ 1930 hrs Medical Examiner October 20, 2010 Penny Leigh 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Wicomico Salisbury Peninsula Regional Medical Center If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Director 213-82-7238 2 X F 08/28/1964 Maryland 46 1 M Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location à 10a State 10b. Count 1 X Yes 2 No or 28a-f show Wicomico Salisbury Maryland hours after death with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1204 N. Division Street 21801 USA 239 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 11 Marital Status 12 Was Decedent Ever in U.S. or items If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Yes Specify.White 3 X Widowed 1 Yes 2 X No specify: 4 Divorced If Yes, Give Year ⋧ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages 1 and 2 should be filed within 72 l Department of Health and Mental Hygene. Important: If item 27 is marked other than "n injury or other traumatic event, the Medical E Baltimore. MD 21215-0036 law 12 paralegal 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Howard Samuel Williams Sherry Leona Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa M. Abbott/daughter 801 Brookmeade Court, Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State Parsons Cemetery 10/26/2010 Salisbury, MD 4 Donation 5 Other Specify: Signature of Fune I Service Licensee 22Home and Address of Funeral Home Professional Association allen 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line.

Hypertensive Cardiovascular Disease Between Onset and /Medica Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and 1 be detached for use as the burial - transi Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Physician/Medical AMENDED item 23a,27 Per ME 1/18/11 G911 EG ▼ UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Month 3 Ectopic pregnancy Live birth 2 Fetal death Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 V Unknown Completed certificate has been ector page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performed? death? ✓ Yes 2 No 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be Other Nursing Home 5 Residence 6 Other this 1 🗸 Yes After t 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Autouration within 24 hours after death.

To the Funeral Director: A 1 X Natural 1 Yes 2 No 5 Pending 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f, Location (Street and Number or Rural Route Number, City 3 6 Could not be Suicide (Specify) Homicide 29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s). Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registral
DHMH 17 Rev 1/2001

OCME 2006

State

27 2010

30. Name and address of person who completed cause Theodore M. King, Jr., MD. Assista

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Assistant Medical Examiner

ORIGINAL

O.C.M.E.

COME

111 Penn Street, Baltimore, MD 21201

October 23, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dav Barbara A. Johnson 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death VICIMICO TENIN SULA ION AC If Under 1 Year If Under 24 Hrs 8. Date of Birth
(Month, Day, Year)
10-10-1950 Social Security Number 9. Birthplace (State or Foreign **Funeral** MD Country) 1 □ M 2 🗶 F Months Days Hours Director 50-1828 60 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1X Yes 2 □ No MD Snow Hill Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a USA 501 Maple Street, Apt. 205 21863 within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2X No
If Yes, Give Black, White, etc. should be filed within 72 hours after cand Mental Hygiene.

is marked other than "natural", or þ 1 X Never Married 2 Married Maryland 21215-0036 SpecifyBlack 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Down & Under Elementary/Seconday (0-12) College (1-4 or 5+) Restaurant <u>Cook</u> Be injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Cora E. Johnson Estee Corner permit. Page 1 and 2 should t Department of Health and Me Important: If Item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1288 Morse Street, NE, Washington, DC 20002 <u>Jabrill Williams/Daughter</u> Baltimore, 20a. Method of Disposition
14 Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 10-16-2010 Snow Hill, MD 4 Donation 5 Other (Specify) Wesley Cem Firm ral Santice Lidensee 917 W. Isabella St. 22. Name and Address of Facility Bennie Smich any i Funeral Home Salisbury 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Multiple disease or condition resulting in death) Organ Medical Due to ras a consequence of): **Examiner** Acquired Immune Deficiency Sundrome Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) physician and s the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 ending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy atter in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ¥ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed 2 🗌 No 1 Yes Yes To the Hospital or Attending Physician: 25. Was case referred to medical director, Be 26. Place of Death (Check only one) P Other: 1 Tes 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this nours after death.

neral Director; After this filled in by the funeral d 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending work 1 Yes 2 No Accident Investigation Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a **To the Funeral D**completed filled Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 10 14/2010 07096

State Registrar md. 2180

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100 E. Carroll St. SAlisbur

32 Registrar's Signatur

Mosha Peters-Horris

31. Date filed (Month, D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 15, 2010 9:00 Рм Martha H. Johnson Medical 4a. Facility Name (if not institution, give street and number) Center 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Forestville Forestville Health & Rehabilitation 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** March 26, 1 □ M 2 🛛 Months Days Hours Min 241-32-9749 Yrs 1929 North Carolina Director Usual Residence of Decedent shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 28a-f 1 X Yes 2 No District Heights Prince George's Maryland 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? tems 23a Funeral 6212 Elmhurst Street 20747 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. and Mental Hygiere. is man ed other than "natural", or i þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 XNo ltimore, Maryland 21215-0036 72 hours after Specify: Black 1 ☐ Yes 2 No Specify: 3 24 Widowed 4 Divorced Completed Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 5th College (1-4 or 5+) Mainten<u>ance</u> Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Alonzo Hinnant Donnie Lofton permit. Page 1 and 2 should se Department of Health and Men Important: If item 27 is mar e any injury or other traumatis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6212 Elmhurst Street District Heights, Md. Quiana Johnson - Grand Daughter 20747 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place October 25, 1 Burial 2 X Cremation 3 Removal from State Lee's Crematory Clinton, Maryland 4 Donation 5 Other (Specify) 2010 22. Name and Address of Facility Stewart Funeral Home, Bale 4001 Benning Road NE Washington, DC 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock in heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ Chronic Obstructive Pulmonary Disease disease or condition Medical resulting in death) **Examiner** Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): and I-transit The law requires that the death certificate be executed Pulmonary Hypertension that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a I for use as the burial-Physician/Medical Dilated Cardiomyopathy Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death signed by the a d be detached for 2 X No 1 ☐ Yes ∠ ⊆ 9 ☐ Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🗌 Yes 2 XNo မှ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending work? 1 Yes 2 No 2 Accident Investigation Suicide 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the land within 2 29b. Signature and titl 29d. Date signed (Month, Day, Year) D 51520 10-20-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20032 Washington, DC 1328 Southern Avenue SE Bahram Pishad, M.D.

Registrar
DHMH 17 Rev 7/2009

31. Date filed (Month, Day Year) OCT 2 5 2010

32. Register's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 20:03 M 2010 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4c. County of Death Baltimore Maryland Medical Baltimore Funeral If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🛣 F Months Min. Nov. 29, 1937 72 217-30-6312 Maryland Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f show any injury or other traumaft event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Hagerstown 1 X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral 428 West Franklin Street 21740 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Black White etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2X No Specify white If Yes, Give Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) homemaker her own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John E. Wilkinson Freda C. Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Cole - son 410 Boones Drive. Lothian, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🔀 Burial 2 🗌 Cremation 3 🗎 Removal from State Cedar Lawn Memorial October 27, 4 Donation 5 Other (Specify) Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between show or heart faile Immedia Cause (Final or heart failure. List only one cause on each line Onset and Death disease or condition resulting in death) Due to (or as a consequence of).

Physician/ Medical **Examiner** P.O. Box 68760

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director; to

Records,

Division of Vital

Ļ	Sequentially list conditions,		
Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a consequence of):	
lical Ex	that initiated events resulting in death) Last	Due to (or as a consequence of):	
<u> </u>			
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) g ☐ Unknown	23d. Date of delivery Month Day Year
Completed by P	Part II. Other significant conditions con	stributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown
Comple			24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No
Be	25. Was case referred to medical examiner?	26. Place of Death (Check	only one)
은	1 🗆 Yes 2 🔽 No	ospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hor	me 5 Residence 6 Other (Specify)
ficate:	27. Manns of Death 1 ☑ Natural 5 ☑ Pending 2 ☑ Accident Investigation 3 ☑ Suicide 6 ☑ Could not be	28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? M 1 Yes 2 No	28d. Describe how injury occurred
edical Certificate:	4 Homicide determined	building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
fedica	(Check 2 L Medical Examine	cian: To the best of my knowledge, death occured at the time, date and place, and er: On the basis of examination and/or investigation, in my opinion, death occurred at Practioner. To the best of my knowledge, death occurred at the time, date and place.	the time, date and place, and due to the cause(s) and manner stated.

164540 9424

St. Baltimore, MD 21201

29d. Date signed (Month, Day, Year) Ochber 21, 2010

State Registrar

WH-10

29b. Signature and title of certifier

rate

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

South

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 10/13/10 Evelyn Wainwright Johnson PM 6:11 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bowie Health Center Bowie Prince George's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 □ M 2 🕱 F Months Days Hours Min. Director 88 220-24-1676 Beltsville. Usual Residence of Decedent 28a-f shov 10a. State 10b. County ar than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD Prince George's **Glenarden** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7805 Glenarden Parkway 20706 Page 1 and 2 should be filed within 72 hours after deathment of Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. Ş 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 🛮 Widowed 4 🗆 Divorced Specify: Completed Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant US GOVERNMENT marked other Be **Baltimore, Maryland** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ၉ Clarence Waters Mary Waters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. Agatha L. Wainwright / Daughter 17815 Merino Drive, Accokeek, MD20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Cemetery 10/25/10 Landover, MD Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue KAn Roses Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiac Dysrhythmia disease or condition minutes Medical resulting in death) Due to (or as a consequence of Examiner Parkinson's Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events years Examine Due to (or as a consequence of): burial-transi Dementia Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical The law requires that the death certificate be Box 68760 attending pl 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Year 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension, Urinary Tract Infection 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 🛛 No 2 🗌 No Yes 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 🔀 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) Bowie Health 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at Center 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No s after death. 2 Accident
3 Suicide М Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical To the Hosp within 24 hou To the Funer completed fil 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 7/2009

State

Registrar

(Check

29b. Signature and title of certified

31. Date filed (Month, Day, Year)

OCT 2 2 2010

Dr. Darcy Ibitoye,

12200 Annapolis Road, Glenn Dale, MD

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month. Day. Year)

October 21, 2010

29c. License number

D51437

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 19. Day 2010 Maxine Cling Kurtz 4:59 p Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country)

TCC **Funeral** June 5, 1922 1 □ M 2 🖺 F Days Hours Months 88 Director 577-24-5260 Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No MD Mon toomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5108 Benton Avenue Funeral 20814 USA ıral", or items ? 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2 🙀 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", White 3 Widowed 4 ☐ Divorced Completed Year or Dates. event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home should be filed with and Mental Hygien 7 is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Ivan Wesley Cling Grace Metcalf Beech traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Robert W. Kurtz/Son 8617 Bali Road, Ellicott City, MD 21043 Date 22, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State Rock Creek Cemetery 2010 4 Donation 5 Other (Specify) Washington, DC 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 21. Signat / e of Funeral Service License 23a, Part 1. Enter the disease, or dom cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) ₽nysician/ Medical Due to (or as a consequence of) Examiner 2 Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the burial Physician/Medical -3010 Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month 0 Month Year Day Pregnant at time of death P.O. 0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Vinknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe certificate 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 1 Yes Other: ဂ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of icate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After tompleted filled in by the funeral 1 Natural × 5 Pending work 1 Tyes Investigation 6 Could not be Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined A \leq Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

□ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person who completed caus Matthew M. Leonard, Md

21

31. Date filed (Month, Day, Year)

edistrar's Signati

e of death (Item 23a) (Type, Print) 8600 Old Georgetown Road, Bethesda, MD 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 2010 1200 October М Dorothy Josephine Harbester Killeen Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death National Lutheran Home Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Days Hours Min (Month, Day, Y **Director** Pennsylvania 166-16-8504 90 Usual Residence of Decedent Page 1 and 2 should be filed within 72 ווסטט ב Imment of Health and Mental Hygiene. rtant: if item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 9701 Veirs Drive 20850 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: White Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Harbester Josephine Esther Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 2201 Wilson Blvd #902, Arlington, Virginia 22201 Rev. John Bradford/Son-in-law Important: If item any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of 1 Burial 2 K Cremation 3 Removal from State 010^{21} 4 Donation 5 Other (Specify) Metropolitan Crem. Alexandria, Virginia 21. Signature of Funeral Service Larensee 22. Name and Address of Facility Hysong Company lle Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 2222 Wisconsin Ave., N.W. Washington, D.C.20007 23a. Part 1. Enter the disease Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) MUDNIL OBSTRUCTIVE Medical Due to (or as a consequence of): , Examiner LHONBRY Sequentially list conditions. Examine rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed ATRIPL FIBRILLATION been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Certificate: To Be Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an has autopsy perform death? this certificate 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) 2 K No 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral (27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Therete du 19 2010 D0051158 OCTOBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

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32. Registrar's Signature

mall no

31. Date filed (Month, Day, Year,

MO 20850-

ROCK VILLE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ **EVANGELINE** KING 2010 9:22 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S HOSPITAL PRINCE GEORGE'S CHEVERLY Date of Day, (Month, Day, 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 M 2 TF 578-40-4136 Yrs Director 1932 SHINGTON, DC Jsual Residence of Decedent 3a or 28a-f show t be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 X Yes 2 No DC WASHINGTON 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a **Examiner must** 51ST STREET N.E. # 102 20019 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married "natural", or within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. BLACK 3 Widowed 4 Divorced Specify: Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working thand Mental Hygiene.

I is marked other than trauntraum life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOUSE KEEPER PRIVATE Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked or any injury or other traumatic even once. ဂ္ STEPHEN COLLINS BEURENA LEWIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALBERT BROWN/SON 3616 KEYSTONE MANOR PLACE DISTRICT HGTS., MD 20747 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) RESURRECTION CEMETERY 9/22/2010 CLINTON, MARYLAND Signature of Funeral Service Licenses J.B. JENKINS FUNERAL HOME, INC. 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Uano 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Immediate Cause (Final Onset and Death Physician, disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transi and Due to (or as a consequence of): physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No signed by the atte Year Month Day 5 Other (specify) Pregnant at time of death the Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🂢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy performed certificate 2X No 2 X 1 Yes director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) _2 🔀 No 1 🗌 Yes မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending injury 1 X Natural 24 hours after death. Funeral Director: A Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 0068294

DHMH 17 Rev 7/2009

State Registrar THEOPHILUS

31. Date filed (Month, Day, Year 0CT 2 1 2010

3001 HOSPITAL BRIVE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regis

BOTWE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year Physician/ LINTON-HAZEL JOY. ANN 2010 9:34 OCTOBER 16 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S BOWIE PRINCE OF WALES COURT 2215 If Under 1 Year If Under 24 Hrs. 9, Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 🗆 M 2 🗓 F FEB 23 Months Days Hours Min 1956 GUYA'NA Director 078-66-0092 Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland or than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at Director PRINCE GEORGE'S BOWIE MD 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20716 USA 2215 PRINCE OF WALES COURT within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Was Decedent Ever in U.S Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2X Married <u>\$</u> BLACK Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE CUSTOMER SERVICE REP 4YRŠ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic even SPENCER ELOUISE STANLEY LINTON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 2215 PRINCE OF WALES COURT BOWIE, MARYLAND 20716 RODERICK HAZEL/HUSBAND 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State LAUREL, MARYLAND MD NATIONAL CEMETERY 10/23/2010 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility J.B.JENKINS FUNERAL HOME, INC. LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 . Part 1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ OF RIGHT UPPER EXTRMITY disease or condition WT Medical resulting in death) Due to (or as a consequence of): Examiner RIGHT BREAST CANCER Dequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-trans and resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the t IF FEMALE use 8 yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 3 in the past 12 months?
1 Yes 2 No for Pregnant at time of death detached 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown RESPIRATORY FAILURE 24b. Were autopsy findings available prior to completion of cause of 24a. Was an DEPRESSION After this certificate has autopsy performed? page 2 1 ☐ Yes 2 👿 No . Yes 2 TV N 26. Place of Death (Check only one) 25. Was case referred to medical the funeral director, Be examiner? Other: 4 Nursing Home 5 🗷 Residence 6 Nother (Specify) 2 🗌 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: To 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 ☐ Yes 2 ☐ No М Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by Medical 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year)

State Registrar 3331

30. Name and address of person who completed cause of death (Item 23a) (Type

ROBINSON REDWAY M.D.

Date filed (Month, Day, Year)

OCT 2 5 2010

D32519

TOLEDOUTERRACE #107 HYATTSVILLE, MARYLAND

20782

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician 5:55 PM 2010 Oct. <u>Gloria Ann Lonomire</u> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h. City. Town, or Location of Death Examiner Carroll Westminster Dove House Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 ▼ F Director 1928 219-20-8232 82 June Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 ☐ Yes 2 🗓 No Director Carroll Westminster 10g. Citizen of What Country? 10e. Street and Number 10f Zip Code Funeral 350 Reams Ct U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. filed within 72 hours after 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married "natural", or Maryland 21215-0036 1 □ Yes 2√2 No Specify ģ Specify: 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 127 is marked other than "r. r traumatic event Elementary/Secondary (0-12) College (1-4or 5+) Hairdresser Beauty Salon 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be 1 Health and Mental ျ Edwin J. Reynolds Margaret Getzdaner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 is : If item 27 or other t Sharon Gordon/daughter 350 Reams Ct., Westminster, MD 21158 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 10/20/2010 Hampstead, MD Carroll Cremation 21. Signature of Funeral S 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA Youl 412 Washington Road, Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebrovascular accident /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) of Vital Records, P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Ulnknown 9 Unknown signed L Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No 2 XN funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: $4 \square$ Nursing Home $5 \square$ Residence Subther (Specify) hospice 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Medical 29a. Certifier 1 [Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 MJL October 18, 2010 D17040 MO 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 215 Washington Heights Medical Center,

Westminster, MD 21157

M.D.

32. Redistrar's Signature

Howard G. Lanham, 31. Date filed (Month, Day, Year)

1 - For State Registra

29b. Signature and title of certifier

Be Completed by Funeral Director

ပ

Physician

/Medical

Examiner

Funeral

For	State of Ma	aryland / E	Departmo	ent of H	lealth a	nd M	lental Hygi	ene		
State Registrar			Certific	ate of	Death		Re	g. No2 ()	10	34847
1. Decedent's Name <i>(First, Middle, Las</i> James	Curtis	I	Ledford	l S	r.	_	2. Date of Death Month October 1	Day	Year	3. Time of Death 11:37 P
a. Facility Name (If not institution, give Ft. Washington Ho			1		r Location of				y of Death Ce Ge	orge's
5. Social Security Number 6. S	Sex 7. Age	e (In yrs. last biri 92	thday) If Un Mont	der 1 Year hs Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Birth (Month, Day 04/29/19	Year) 18	C01	place (State or Foreign ntry) nessee
Usual Residence of Decedent 10a. State 10b. County		10c. City, Towr	or Location							10d. Inside City Limits
Maryland Prince (George's	Ft. V	Vashing 10f.	zip Code			10	ng. Citizen of	What Cou	1 ☐ Yes 2X25No ntry?
12801 Lampton La				2074		1.0 (0.	- N- V N-	USA		and the state of t
11. Marital Status 1 ☐ Never Married 2 ☐ Married 3★★Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? ty Tyes 2 ☐ I If Yes, Give Year or Dates:			specify Cub	Alspanic Orig an, Mexican, Specify:	Jin? (Spo Puerto	ecity Yes or No- Rican, etc.)		ack, White,	ican Indian, etc. hite
15. Decedent's Ed (Specify only highest grade) Elementary/Secondary (0-12)			Decedent's L (Give kind of life. DO NO	work done T use retire	during most d)		ing	16b. Kind of E		
17. Father's Name (First, Middle, Last))	COL	nputer	Syste	18. Mother	r's Name	e (First, Middle, M			vernment
Wesley Fonzo	Ledfor			. (24	Vest		L.	Sear		i- Codel
James C. Ledford			12801	. Lamp	ton La	ane	Ft. Wash		n, Ma	ryland 20
20a. Method of Disposition ★★ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif			f Disposition (ry, crematory (incoln							Maryland
21. Signature of Funeral Service Licer	nsee				ess of Facility	Geo	orge P. H Oxon H	Kalas i	Funer	al Home,P.A
23a. Fort. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	the death. Do ne.	not enter the r							Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. A The Due to (or as	a consequence		a.do	incl	a 1	Piden			54.
that initiated events resulting in death) Last	Due to (or as	a consequence	of):	,						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal death	3 ☐ Ectop 5 ☐ Other	oic pregnand (specify) _	су				ate of deli	very Day Year
Part II. Other significant conditions o	contributing to death b	ut not resulting in	n the underlyin	ng cause gin	ven in Part I.			oacco use c <i>o</i> s 2 □ N <i>o</i>	ntribute to 3□ Pro	the cause of death?
							24a. Was an autops perform	v	prior to death?	topsy findings available ompletion of cause of
25. Was case referred to medical examiner?	11- 2-1			1 -		of Deat	h (Check only on			
1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Impatie 28a. Date of Inju (Month, Da	ry 28b.	itpatient 3 Time of Injury	28c. Inju Wo	ry at		ome 5 Reside			ify)
2 Accident Investigation 3 Suicide 6 Could not b 4 Homicide determined		ury - At home, fa c. <i>(Specify)</i>			.,,,, ,,,,		28f. Location (St City or Town	reet and Nun	nber or Ru	ral Route Number,

29c. License number

29d. Date signed (Month, Day, Year)

13 12-201;

lisings for N is 10/ file Arlyta M120/(

Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

• To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification: To Be Completed by Physician/Medical

/VA

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-08057 State of Maryland / Department of Health and Mental Hygiene Anthony Mumford 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day October 20, 2010 0900 hrs Medical Examiner Anthony M. Mumford 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Worcester Williams Street and North Main Street 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 7. Age (In vrs. last birthday) Funeral 5 Social Security Number Days Months Hours Director Country) MD 222-52-4167 1 XM 50 Sept 29,1960 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 1 Yes 2 No Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Ex miner must be notified at once. Bishopville Worcester Director 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number 21813 USA 13306 Old Stage Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Black 12. Was Decedent Ever in U.S. White, etc. African-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married 2 X No Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: American þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) timore, MD 21215-0036 Retail Sales Maintenance Technician 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Natalie Briddell James H. Mumford, Sr. Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ٩ 13306 Old Stage Road, Bishopville, MD 21813 Natalie Mumford/mother 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 10/26/10 Bishopville, MD Curtis UMC Cemetery Department Donation 5 Other Specify 22. Name and Address of Facility Lewis N. Watson Funeral Home, PA 1618 West Rd., Salisbury, MD 21801 21. Signature of Euneral Service Licenses 23a, Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and **IModita** Death Multiple injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical the attending physician a ed for use as the burial -X UNPENDED AMENDED 23a, 27,28a-f,per ME g909 11/30/10 TT certificate be Box 68760 IF FEMALE: 23d. Date of delivery 23c. If ves. outcome of pregnancy 3b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown signed by t be detache 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. Ď 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed this certificate has been a director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy performed? death? ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene 1 🗸 Yes After 1 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Oriver of auto fixed object 27. Manner of Death 1 Natural 5 Pending 1 Yes 2 X No filled in by the fi 8:55 am 10/20/10 2 X Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Williams St and north ain St. Berlin, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 Could not be Suicide roadway determined Homicide 29a. Certifier 1 (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal

the Hospital or Attending Physician: No the Hospitat or within 24 hours after death.

> 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD. Assistant Medical Examiner

29b. Signature and title of certifie

31. Date filed (Month, Day, Year) 32. Registrar's Signature ranks

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

OCME

29d. Date signed (Month, Day, Year)

October 21, 2010

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
RegistraMEND#8perINF, 10/25/10, BMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October Michael Melas 20110 9:15am Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Caseu House Rockville Montaomeru Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. D1tOptB218 -1925 **Funeral** 1 X M 2 🗆 F Months Davs Hours Director Pennsulvania 201-20-5088 84 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 X No Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 15115 Interlachen Drive, #711 20906 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No 1942-Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Specify 3 Divorced 4 Divorced 1945 White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) f Health and Mental Hygiene. Item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Tech General Electric Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Catherine George Melas (Unknown) 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Persa Melas - Spouse 15115 Interlachen Dr.. #711. Silver Spring, MD20906 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or oth Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/25/2010 of Heaven Cem. Silver Spring. MD Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. Sann 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Days Immediate Cause (Final Physician/ disease or condition resulting in death) Sepsis Medical Due to (or as a consequence of) Examine Cholecustitis Daus Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Chronic Lymphoid Leukemia Months signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗓 Unknown within 24 hours after death.

To the Funeral Director. After this certificate has been completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Hospital Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 \(\hat{\text{\text{Nursing Home}}}\) 5 \(\hat{\text{Residence}}\) 6 \(\mathbb{K}\) Other (Specify) HOSpice 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No X Natural 5 Pending iniury Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) D37142 10-19-2010

Registrar DHMH 17 Rev 7/2009

State

egistrar's Signatur

1355 Piccard Drive, Rockville, Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D.,

Geoffrey Coleman, 31. Date filed (Month, Day, Year)

OCT 22

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10:39 P M OCTOBER 16. GREGORY DEAN MAXEY 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS 6. Sex 1**X** M 2 □ F If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours (Month, Day, Ye Director 53 1957 OKLAHOMA 448-64-0986 Usual Residence of Decedent 28a-f show iral", or items 23a or 28a-f shor Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MARYLAND QUEEN ANNE'S **GRASONVILLE** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 297 KENT NARROWS WAY NORTH, D-66 21638 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ♣ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married "natural", or δ 1 Yes 2 No Specify. Specify: WHITE Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) PARKING MANAGEMENT PARKING permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important; If item 27 is marked other any injury or other traumatic event, t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည WALLACE MAXEY SUE MARIE JOHNSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21638 297 KENT NARROWS WAY NORTH, D-66 GRASONVILLE, WALTER BAUMGART/PARTNER 20a Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State BESTGATE MEMORTAL PARK 1 Burial 2 Cremation 3 Remo OCTOBER 2010 4 Donation 5 X Other (Specify) ENTOMBMENT ANNAPOLIS, MARYLAND Signature of Funeral Service Licensee 2. Name and Address of Facility ELLOWS, HELFENBEIN & NEWNAM FUNERAL OG SHAMROCK ROAD, CHESTER, MARYLAND 23a. Part 1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin Cause (Disease or iinjury that initiated events resulting in death) Last physician and s the burial-trans Due to (or as a consequence of Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Pregnant at time of death 1 Yes 2 9 Unknown Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, this 27. Manner ath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at e Hospital or Attending P 124 hours after death. e Funeral Director; After the pleted filled in by the funeral Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined within 24 hours a

To the Funeral D

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 3306

State

Baltimore, Maryland 21215-0036

68760

Records,

Division of Vital

Registrar

medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2003

		1 - For State Registrar	State of Maryla	_	rtificate of E			gien Reg. N	211111	34851
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Examin	ier	303 OAK STREET			4b. City, Town, or			4	c. County of Deat QUEEN A	
Funeral		5. Social Security Number 6. S		last birthday)	If Under 1 Year	ENSVI	4 Hrs. 8, Date of Bir		9. Birl	NNE 5 thplace (State or Foreign
Director		025-66-8336	□ M 2 X F 52		Months Days	Hours	Min. FEB. I	y Year)	1958 Î	RELAND
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or 28	ä	MARYLAND QUEEN 10e. Street and Number	ANNE 5		10f. Zip Code	ւևևե	1	10a C	itizen of What Co	
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nould nd Me s mar umati		19a. Informant's Name/Relationship (1		19b. Mailii	ng Address /Street a		or Rural Route Numbe		or Town State 7in	Code)
d 2 shalth a alth a 27 is		EDWARD MOLLOY/HU	SBAND				STEVENSVIL			•
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hyglene. Importanent of Health and Mertal Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ▼Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		Place of Dispo	sition (Name of Peto CR DMA da	ON O	CTOBER 20,	20c. l	ocation - City or	
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B a m D e		/ LARIE (1	10	6 SHAMROC	K ROAI	O, CHESTER	, M/	ARYLAND,	21619
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Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn. 1 Live Birth 2 Fet		Ectopic pregnancy	У			23d. Date of del	,
deat the at	/sici	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	death 5	Other (specify)	,		- 1	Month	Day Year
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sician: The law is certificate has birector, page 2 s	Completed						autor	psy ormęd?	prior to death?	completion of cause of
an: Th tificatu or, pa		25. Was case referred to medical			26 Pla	ace of Death	(Check only one)	2 X N	lo 1 Yes	2/ No
ysicia s cert direct	To Be	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	_ Othe	r:	ing Home 5 Resid	dence	6 Other (Speci	(6/)
ng Ph ter thi neral		27. Manner of Death	28a. Date of injury (Month, Day, Year)	28b. Time of injury		at	28d. Describe h			199
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of the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2 Medical Exam	sician: To the best of my know iner: On the basis of examinations of examinations of the bast of m	on and/or invest	tigation, in my opinior	n, death occu	irred at the time, date a	and place	e, and due to the d	ause(s) and manner state
To the within To the complete	Σ	only one) 3 L Certifying Nur 29b. Signature and title of certifier	se Practioner: To the best of m	iy knowledge, d	29c. License				s) and manner as: ate signed (Month	
7		· KWK	uu_			4731			10/18/	
0.05		30. Name and address of person who		n 23a) (Type, F					. ,	
SWS J		SUZANNE NIEMELA, 1			,	101. (CHESTER. MA	ARYT	AND 216	19
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Registra	ar	OCT 18 2010) Service S.	par						

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

10-08015 Alexander Hamiltor	Please Type or Print in Black Indelible Ink. Ensure All Cop Mellon State of Maryland / Department of Health and Mental 1-For State Registrar Certificate of Death	Hygiene	gible. 2010	34852
Physician/ Medical Examine	Decedent's Name (First, Middle,Last)	2. Date of Dea Month	Day Year	3. Time of Death 2030 hrs
Incarcal Examine	4a. Facility Name (if not institution, give street and number) 996 Miles Court 4b. City, Town, or Location of Dec	October 1	4c. County of Deat Anne Arunde	.h
Funeral Director		8. Date of 8 in JUNE 19	th(MM/DD/YYYY) 9. 8i 26, Forei	rthplace (State or gn_MARYLAND ountry)
nd show any rec. Or	Usual Residence of Decedent 10a. State			10d. Inside City Limits 1 Yes 2 No
n the Maryland 3a or 28a-f sh. otified at once			Og. Citizen of What Cou UNITED ST	í
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygienc. Important: If itien 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No 1 Yes, specify Cuban, Mexican, Puer or Dates: 1 Yes 2 X No specify:	rto Rican, etc.)	White, etc. Specify: W	rican Indian, 8lack,
5-0036 ed within 72 hours stygiene. other than "natur the Medical Exam Completed I		etired)	EDUCATI	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	I GREGORY S. MELLON I DEBORA	me (First, Middle, MAH L. C)	Maiden Surname) ULLUM MEL	LON
MD 21 ad 2 should thth and Me n 27 is ma numatic ev	GREGORY S. MELLON / FATHER 996 MILES COURT,	ARNOLD	, MARYLAN	D 21012
Baltimore, permit. Pages I an Department of Heal Important: If iten injury or other tra	4 Donation 5 Other Specify: CREMATORY	CT. 21, 2010	20c. Location - City of RIVERDAL	·
	21. Signature of Funeral Service Monday 22. Name and Address of Facility TERRENCE L. JOHNSON#M00993 4433 WHITE PLA	HNSON FULL INS LAND	UNERAL SE E,WHITE P	
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	c or respiratory arre	est, snock, or neart	Approximate Interval 8etween Onset and Death
ıt xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated			
2 2 111				
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed the hours after death. Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial - trans all Certification: To Be Completed by Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 5 Other (Specify) 9 Unknown			Day Year
P.O. es that the igned by I be detached by I by PP PP PP PP PP PP PP PP PP PP PP PP PP			obacco use contribute to 2 ✓ No 3 ☐ Pro	the cause of death? bably 4 Unknown
Division of Vital Records, tall or Attending Physician: The law require rs after deer. After this certificate has been sited in by the funeral director, page 2 should bertification: To Be Completed		24a. Was a autop perfor	sy prior to death?	utopsy findings available completion of cause of
tal R cian: T certific ector, p Be C	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other, 4 Nur.			
on of Vinding Physich. After this efuneral different of To	1 Ves 2 No Paper of Death 28a Date of Injury 28b Time of Injury 28c Injury at Work?		Residence 6 🗸 Othe now injury occurred t self	r. ocene
Division o Hospital or Attending 24 hours affer death. Rely filled in by the fune al Certification:	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 4 Homicide 4 H	or Town, S	Street and Number or Rutate)	ural Route Number, City
Hospit 24 hour 24 hour Funers tely fill	4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a	<u> </u>	· · · · · · · · · · · · · · · · · · ·	ted.

10B4

Russell Alexander MD. As

State 31. Date filed (Month, Day, Year)

Registrar OCT 2 1 2010

29b. Signature and title of certifier

Assistant Medical Examiner

32 Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a)

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

October 19, 2010

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🖺 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 7:48am Howard A. Moss October Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bethesda Suburban Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Y April 02 Social Security Number . Age (In yrs. last birthday) **Funeral** 1 **X** M 2 □ F Months Days Hours Ohio 81 Director 286-22-8734 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director 1 Yes 2 X No Rockville Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Numbe Funeral 20852 U.S.A. 11510 Parkedge Drive 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. ģ 1 Never Married 2 X Married X Yes Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Korea White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) **5+** Elementary/Seconday (0-12) Developmental Psychologist NIH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Esther Katz Louis Moss 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 11510 Parkedge Drive, Rockville, Maryland 20852 Adrienne Moss - Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Garden of Remembrance 10/18/2010 Clarksburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee 100/294 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Adenocarcinoma of Unknown Primary disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner Due to lor as a consequence of cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 X No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) æ HOWARD examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 🗶 No 1 ื Inpatient 2 🗆 ER/Outpatient 3 🗀 DOA မြ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes 1 X Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 10+1 October 16, 2010 D62234 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Manish Agrawal

OCT 21

31. Date filed (Month, Day, Year)

M.D.

9707 Medical Center Drive. Suite 300. Rockville. MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 34854 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 2010 James Henry Mason, Jr. 7:30 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1514 Mayfield Road Edgewater Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. Sex. 1 DAM 2 □ F 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Washington, DC Days Hours 9/9/1954 **Director** 228-82-2827 56 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1514 Mayfield Road 21037 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. δ 1 Never Married 2 X Married 1 Yes 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Divorced Completed White Year or Dates permit, Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hyglene. Important If item 27 is marked other than "natur any injury or other traumatic event, the Medical! 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Department of the Elementary/Seconday (0-12) College (1-4 or 5+) Special Agent Interior vears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ James Henry Mason Colene Schmidt Frederick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa Mason/ Wife 1514 Mayfield Road, Edgewater 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-16-2010 Kalas Crematory Edgewater, MD 21. Signatur Propinsi Se de Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Ed.
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Edgewater, MD 21037 Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ LANZER OF ESOPHAGO disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consecuence offi Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 1 Tes Yes 2 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nerse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only of 29b. Sign atu

State Registrar Name ar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 10 10 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Joyce D. MacMillan 2010 6:00 P M October 0 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 DM 2 1 F Days July 17. 1944 Months Hours Min. Connecticut Director 216-42-8627 66 Usual Residence of Decedent important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🛱 No Maryland Arnold Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 119 Collington Court 21012 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ģ 1 Never Married 2 Married White and 2 should be filed within 72 hours afte Health and Mental Hygiene. em 27 is marked other than "natural", 1 ☐ Yes 2 X No Specify: If Yes Give 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Educator Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Arthur J. Derflinger Julia Demanchyk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 4315 Gadwall Place, Virginia Beach, VA 23462 Jessica J. Meissner/ Daughter 20a. Method of Disposition
1 □ Burial 2 █ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 Other (Specify)

21. Signatur Historia Service Licensee Kalas Crematory 10/18/10 Edgewater, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ondet and Death Immediate Cause (Final Physician/ Anoxic encephalopathy disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transil that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) 4 Pregnant : 9 Unknown Pregnant at time of death signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Covonary 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sis completed filled in by the funeral director, page 2 should to End Stage Renal Disease 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred ē 1 Natural
2 Accident
3 Suicide 5 Pending work? 1 ☐ Yes 2 ☐ No Certifical Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) werd Berk, My

State Registrar

Maryland 21215-0036

Baltimore,

Box 68760

P.O. I

Records,

Division of Vital

DHMH 17 Rev 7/2009

parke

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

'DEPD

OCT 19

31. Date filed (Month, Day, Year)

BECK, M

32. Registrar's Signature

D46052

2001 Medical Parkway annapolos, MB

10/15/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MCIFO Month 55 PM Medical 2010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baitimore **Funeral** (In yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 29 9. Birthplace (State or Foreign 216-42-8498 1 🔀 M 2 🗆 F Days Months Hours Year) **Director** Maryland 1944 Usual Residence of Decedent 28a-f show 10a. State 10b. County the Medical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Severna Park 1 Ves 2 X No 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 13 Severndale Road 21146 USA "natural", or items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 \(\text{No. 196} \) 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 1963 þ Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify. White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Clerk Safeway Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers or is marked or Daniel B. McLeod, Jr. Julia T. Simpson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2017-2024 Covierna Park, MD 21146 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Doris Vose / Sister 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State October 2010 Metro Crematory, INC. 4 Donation 5 Other (Specify) Baltimore, MD Signature of Funeral Service Licenses 23 Name and Address of Facility, P.A. Ballanco x Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the dise, se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Immediate Cause (Final Physician/ HRONIC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month signed by the a 9 Unknown P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 23e. Did tobacco use contribute to the cause of death? Records, TENSION page 2 should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown een has t 24a. Was an 24b. Were autopsy findings available Hospital or Attending Physician: The law prior to completion of cause of death? autopsy performed cerlificate 1 🗌 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 🗌 Yes ဂ Other: 1 Inpatient 2 ER/Outpatient 3 DOA this Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1, Naturai 5 Pending injury Certificat work 2 Accident
3 Suicide
4 Homicide within 24 hours after death

To the Funeral Director: /
completed filled in by the f 2 🗌 No Investigation 6 Could not be 1 Tyes Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death only one diet the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month) Day, Year) 211 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASNERM 0CT 1 8 2010 31. Date filed (Month 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar		aryıanı	•	tificate of L		Mental Hy	giene Reg. N	21111	34857
	Physicia Medio		Decedent's Name (First, Middle CLAUDE	e, <i>Last)</i> E .		j	MOTEN		2. Date of De Month 10-	eath 17-2	ay Year	3. Time of Death 10:21 A M
	Examin		4a. Facility Name (if not institution		קקי		4b. City, Town, o.			40	c. County of Death	
	Funeral Director		5. Social Security Number 577–50–0165			st birthday) Yrs.	If Under 1 Year Months Days			th		place (State or Foreign
	and show	tor	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	cation	<u> </u>				10d. Inside City Limits
	e Maryl r 28a-f notified	Direct	MD PRINCE	E GEORGE	FT.	WASH:	INGTON			10.0		1 X Yes 2 □ No
	h with th ns 23a o must be	Funeral Director	11904 BIZE					20744		J	itizen of What Cou	ntry?
036	s flied within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	 11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 XDivorced 	If Van Cive	Ever in U.S. No		Vas Decedent of H i Yes, specify Cuba ☐ Yes 2 🛣 No		Specify Yes or No- erto Rican, etc.)		14. Race - Americ Black, White, Specify: BLA	etc.
21215-0036	72 hour	Completed	(Specify only high	ent's Education est grade completed)		(Give I	lent's Usual Occup kind of work done of NOT use retired)		rorking	16b. l	Kind of Business In	dustry
	d within lygiene. ther tha nt, the l	Be Cor	Elementary/Seconday (0-12)	5+ YEARS	5+)		TIONAL AI				PUBLIC S	CHOOLS
Maryland	2 should be filed in and Mental Hyg It is marked oth traumatic event.	To B	17. Father's Name (First, Middle, FISHER	MOTEN				18. Mother's N GLAYDS	lame (First, Middle, M. WH	Maiden ITE	Surname)	
	of Health and Ment of Health and Ment fitem 27 is marked rother traumatic		19a. Informant's Name/Relations MICHELE D. MOTE	hip <i>(Type, PrinDAUGHT</i> EN—BRIDGES	ER	ı	g Address (Street a		Rural Route Numbe		r Town, State, Zip	Code)
Baltimore,	ge 1 and at of Hea : If item or othe		20a. Method of Disposition 1 ↑ Burial 2 ↑ Cremation	3 Removal from State	ce	ace of Dispo	sition (Name of natory or other plac	ce)	Date	20c. L	ocation - City or To	•
altiir	permit. Page 1 a Department of I Important; If ite any injury or ot		4 ☐ Donation 5 ☐ Other (TTMC		EMO . CEM . Name and Addres		-25-2010 'INCKNEY-		TLAND, M IGLER F.	
n	e a H Pe	2	23a. Part 1. Enter the disease, o	r complications that caused	kne death						OC 20002-	5236 Approximate
j	Pnysician		shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on each line	e. ()		STOLE)				Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a		,	LURE					
	ed	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a HYPERTE	•							
	icate be executed I physician and s the burial-transi	al Exa	that initiated events resulting in death) Last	Due to (or as a								
2/60	ificate b ig physic as the b	Medical	IE ECMAL C.	d								(a == 3; = === 3
BOX PS	To the Hospital or Attending Physician: The law requires that the death certificate be executed within E4 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal	death 3 [Ectopic pregnand Other (specify)	÷y			23d. Date of delive Month	ery Day Year
S, P.O.	uires that th n signed by uld be detad	ed by Pł	Part II. Other significant conditi ESRDISEASE ON								use contribute to t	ne cause of death?
vital Records,	The law req cate has bee page 2 sho	Completed by	PERIPHERAL NEU	ROPATHY					24a. Was auto perfo 1 \(\sum \text{Yes}	psy ormed?	prior to co death?	psy findings available mpletion of cause of
VITal	ysician: s certific director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 【 No	Hospital:	ent 2 🔽 E	R/Outpatien	Oth	ace of Death (Ch		dence	6 ☐ Other (Specify	v)
DIVISION OF	arhing Phy ath. r: After thi ne funeral o	Certificate: 1	27. Manner of Death 1 Natural 5 Pending Pend	28a. Date of injur (Month, Day gation	ry 2	28b. Time of injury	28c. Injury work	/ at	28d. Describe I			/
DIVISI	ital or Atte urs after de ral Directo lled in by ti		3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	nined 28e. Place of Inju- building, etc	C. (Specify)				City or Tov	vn, State		
	ne Hosp n 24 ho ne Fune pleted fi	Medical	(Check 2 🖳 Medic al I	Physician: To the best of Examiner: On the basis of ear Nurse Practioner: To the	xamination	and/or invest	igation, in my opinic	on, death occurre	d at the time, date a	and place	e, and due to the ca	use(s) and manner stated.
	20 Sometimes	0	29b. Signature and title of certifie	OP Com	rell	Ma	29c. License D0029				ate signed <i>(Month,</i> '19/2010	Day, Year)
	A.		30. Name and address of person WENDELL MC				rint) ERCANTILE	TANE	LARGO M	D 20	77/	
	Stat Registra		31. Date filed (Month, Day, Year) 0CT 2 2 201	22 Pagintro	ar's gignatu	sarks	/	HIVE	mang∪, M		., / 4	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34858 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Lucy Mae Meador Oct. 20, Day 2010 9:00 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince George's Greenbelt 5801 Cherrywood Lane, #103 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. Sept 6, The Plains, VA 1930 **Director** 80 228-42-4433 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Prince George's Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20770 5801 Cherrywood Lane, #103 death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after White 1 ☐ Yes 2 A No Specify: 3 Widowed 4 X Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bindery Bookbinder 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဨ Rosie Agnes Dawson William Sudduth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 106 Bramblewood Dr., Ocean Pines, MD 21811 Charlotte Carroll - daughter 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 10/26/10 Brentwood, Maryland Fort Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ disease or condition resulting in death) mosths Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Obstructive Pulmonery Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an therosclerotic Heart performe Yes 2 🔀 No 2 🗌 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 2 🖾 No 1 🗌 Yes Other: 1 Inpatient 2 Inpatient 3 Inpotent 2 Inpatient 3 Inpotential 2 Inpatient 3 Inpotential 2 Inpatient 3 I 4 Nursing Home 5 A Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work? 1 \(\subseteq \text{Yes} 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D 37934 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) phanle -0G-110

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month 0347 hrs 2010 Marshall Physician/ October Μ. 4c. County of Death Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Montgomery Park Washington Adventist Hospital Takoma DC Country) 8. Date of Birth (Month, Day, May 23 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 6. Sex Social Security Number Hours Funeral 1 □ M 2 🔀 F 90 578-30-<u>1</u>476 Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location ith and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. Count 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland 1 Yes 2 X No Directo Washington DC 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20001 Funeral 1128 10th Street NW Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: Black δ 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 3 X Widowed 4 Divorced Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) DC Public School College (1-4 or 5+) Elementary/Seconday (0-12) Cook 12th 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Gladys Miller မ Edward Black 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 1128 10th Street NW, Washington DC20001 Valerie Chisholm(Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 💢 Burial 2 □ Cremation 3 □ Removal from State Oct 22,10|Triangle Virginia Quantico Nat Cem 4 ☐ Donation 5 ☐ Other (Specify) 20011 22. Name and Address of Facility 21. Signatur Funeral Service Licensee Tyrone J. Young 719 Kennedy St. NWWashDC Approximate Interval Between Onset and Death not enter the mode of dying, such as cardiac or respiratory arrest. 23a. Part 1. Enter the disease, or complicat shock, or heart failure. List only one of Immediate Cause (Final disease or condition ons that caused the death. use on each line. Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Examine been signed by the attending physician and should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Day Year Month in the past 12 months?
1 Yes 2 No
9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown ò Completed Were autopsy findings available prior to completion of cause of 24a. Was an death? performed? Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 26. Place of Death (Check only one) 25. Was case referred to medical completed filled in by the funeral director, Be examiner? Other: Hospital 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28d. Describe how injury occurred 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: Natural 5 Pending 2 Accident
3 Suicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hours a Medical (Check only one 29c. License number 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year

ph # 216.

of person who completed cause of death (Item 23a) (Type, Print)

701 Kando

10-08117	
Vicky Martinez	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

vicky iviarti	inez		1- For State Registrar	State	of Maryla		artment o e <i>rtificate o</i>			Mental I	Hygiene	Reg. N	201	0	34860
Phy Medical E	ysicia xami	an/	1. Decedent's Name (First Vicky Ela								2. Date of D Month October	eath Day	/ Year	3	3. Time of Death 2016 hrs
			4a. Facility Name (if not i			nber)		4b. City, To Greenb		ocation of Dea		ŀ	4c. County of E Prince Ge		3
	neral ector		5. Social Security Number 213-58-95	80	M 2XF	7. Age (In yrs. 58	last birthday)	If Under Months	1 Year Days	If Under 24H Hours M	lrs. 8. Date of lin. August		M/DD/YYYY) 9	Birthporeign Coun	Riverdale,
	any		Usual Residence of Dece 10a. State 10b.	edent County		10c. City	y, Town or Loca	ion						- 1	0d. Inside City Limits
yland	or 28a-f show fied at once.	ţ	Maryland P	rince (George':	s Gre	eenbelt	1 tot 7: 0				10. 0			1 X Yes 2 No
the Mar	3a or 28a otified at	Director	57 L Ridg	e Road				10f. Zip C	ode 2077	0		10g. C	itizen of What USA	Country	y?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	or items 2. must be n	Funeral	11. Marital Status 1 X Never Married 2		12. Was Dece Armed For 1 X Yes	ces?	lf Y	es, specify (Cuban, I	Mexican, Puer	Specify Yes or r to Rican, etc.) panish	No-	White, e	tc.	n Indian, Black,
ours afte	atural", caminer	à	3 Widowed 4 15. Decedent's Education		If Yes, Give Year or Dates: y highest grade		16a. Deceder		cupation	n (Give kind o	f work done	16b.	Specify: W		
1036 vithin 72 ho ene.	er than "na Medical Ex	Completed	Elementary/Secondary		College (1-	4 or 5+)		ost of workir cy Ana	lyst				Post 0	ffi	ce
1215-C I be filed v	rked oth	Be	17. Father's Name (First, Feliberto	C. Mar							ne (First, Middle Reese	, Maide	n Surname)		
AD 21 2 should 1 and Me	27 is ma matic er	٩	19a. Informant's Name/Re Tracey M.			ighter					r Rural Route N ykesvil				ip Code)
re, N s 1 and 3 of Health	If item		20a. Method of Disposition	n		20b.	Place of Dispos crematory or ot	ition (Name			Date		. Location - Cit		own, State
I ltimo nit. Page artment o	ortant: ry or otl	1	4 Donation 5 C 21. Signature of Funeral	ther Specify:			etropolita	n Crem	-		/28/2010	_			Virginia
			Barole	RAL RO	yew	10 1 0	Ga	sch's	Fune	eral Ho		Hya	attsvil	le,	re Avenue MD 20781
Physic /Med Exami	tical		23a, Part I. Enter he dise failure. List only one Immediate Cause (Final of	e cause on eac	h line. Alcoho		n. Do not enter t	ne mode of d	iying, su	ich as cardiac	or respiratory a	rrest, st	nock, or heart		Approximate Interval Between Onset and Death
LXaiii	inei		or condition resulting in d	h	ue to (or as a c	consequence o	of):								
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60, ate be exe	ysician a burial -	ledic.	IF FEMALE:		AMENDED 23a,27	per M	E g909	11/18/	10	TT				\perp	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	ned by the attending physician and detached for use as the burial - transit		23b. Was decedent pregna past 12 months?	ant in the Unknown	23c. If yes, ou 1 Live bin 4 Pregnar	th nt at time of de	2 Fe	tal death ner <i>(Specify</i>		Ectopic pregr	nancy	23	3d. Date of dela Month	Day	Year
O. B	ed by the letached	by Phy	Part II. Other significant	conditions of			resulting in the u	nderlying ca	use give	en in Part I.		_			cause of death?
ords, P	s been sign should be	Completed b									24a. Wa			e autop	sy findings available
Reco	certificate has been ector, page 2 should		25. Was case referred to					- 00	01	Dorth (Obser)	1 ✓ Yes	ormed?		h? Yes	2 No
Vital hysician	this cert I directo	To Be	examiner?	<u> </u>	spital: 1 Inp	patient 2	ER/Outpatient			Death (Check	ing Home 5	Resid	ence 6 🗸 0	ther: S	cene
on of anding P.	r: After he funera		27. Manner of Death 1 X Natural 5	Pending	28a. Date of (Month, D	f Injury Day,Year)	28b. Time of I			at Work?	28d. Describe	how in	jury occurred		
Divisic pital or Atte urs after des	To the Funeral Director: After this certificate ha completely filled in by the funeral director, page 2	ertification:	2 Accident 3 Suicide 6 4 Homicide	Investigation Could not be determined	28e Place	of Injury - At h	ome, farm, stree	t, factory, of	fice build	ding, etc.	28f. Location or Town,		and Number o	Rural	Route Number, City
D To the Hospital within 24 hours	the Fundappletely f	32		al Examiner:	On the basis of	examination a	ge, death occur and/or investigat								ause(s)
.≱. ₹	F 8	¥ ₹	29b. Signature and title of		ind manner sta	iou.		i	icense n				Date signed (Day, Year)
0			MQ.UJONES 30. Name and address of	person who co	mpleted cause	of death (Item	1 23a)		D.C.M.	C.		100	tober 24, 2	010	
K V	A		Margarita Korell	MD. Ass	istant Medi	cal Examin	ner 111 Pe	enn Stree	t, Balt	imore, MD	21201		·		
P	Sta enisti	ite	31. Date filed (Month, Day	NO A	32. Regi	stra s Signa	E Car								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October Day 8 13:17 M 2010 Medical Facility Name (if not institution, give street and number **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 4006 Carozza Court Temple Hills Prince George's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) SC 8. Date of Birth **Funeral** 1 ☑ M 2 ☐ F 247 72 7613 68 8/12/6 9-1 9-42 Director Usual Residence of Decedent show 10a. State should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director "natural", or items 23a or 28a-f MD Prince George' Temple Hills 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4006 Carozza Court UŠA 20748 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married 9 1 Yes 2 No. 1 - 66 Baltimore, Maryland 21215-0036 1 Tes 2 No Specify Specify:Black 3 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Seconday (0-12) 12th College (1-4 or 5+) Bureau of Engraving ice Operation Sqt. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret Crawford Arthur H. Neil, Sr. permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Agnes T. Hill/ Fiancee 4006 Carozza Ct. Temple Hills, MD 20748 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place MD Veterans Cem. 10/25/2010 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lic 22. Name and Address of Facility Briscoe-Tonic Funeral Home 2294 Old Washington Rd.Waldorf,MD 20601 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) oronari Medical Due to (or as a consequency of) Examiner Sequentially list conditions. Examine trany, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury ner the burial-tran that initiated events resulting in death) Last Due to or as a consequence been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Year 4 Pregnant a 9 Unknown 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 23e. Did tobacco use contribute to the cause of death? Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has I funeral director, page 2 s autopsy performed death? 1 🗌 Yes 2 2 🗌 No 25. Was case referred to medical examiner?

1 Yes 2 No completed filled in by the funeral director. Be 26. Place of Death (Check only one) Hospital Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ■ Residence 6 □ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 🗌 Yes 2 🗌 No Accident Investigation after death Director: / 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined า 24 hours ย e Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death 7339+ 31. Date filed (Month, Day, Year) 32. Re State OCT Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician NOISON October /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death **Examiner** St. Thomas More Nursing Home Hyattsville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 6. Sex **Funeral** Months Days Hours Min 1 □ M 2 😾 F 578-54-2636 72 Director Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location show th and Mental Hygiene. ? is marked other than "naturel", or Items 23a or 28a-f shov traumatic event, trained at training and the notified at Director DC Washington 10e. Street and Number 10f. Zip Code 218 57th Place NE 20019 Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be f Major Jackson Bertha Alford ဥ Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is eny Injury or other trau once. Alonzo Nicholson (Husband 218 57th Place NE Washington, DC 20019 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify)

10/22/2010 Brentwood, MD 21. Signature of Funer | Se Mg Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home Kuhet 3401 Bladensburg Rd. homesou. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Due to (or as a consequence of)

Due to (or as a consequence or):

Due to (or as a consequence of):

Brentwood, MD 20722

20c. Location - City or Town, State

2. Date of Death

8. Date of Birth (Month, Pay, Year 3/30/1938

16,

2010

Prince George's

United States

Race - American Indian Black, White, etc.

Specify: Black

16b. Kind of Business/Industry

Domestic

4c. County of Death

10g. Citizen of What Country?

6:15

9. Birthplace (State or Foreign

10d. Inside City Limits

1 □Yes 2 □ No

Washington, DC

Physician /Medical Examiner

burial-tran

the

attending ph e asn

ed by the a detached f

been signed by should be detacl

certificate has page 2

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I

é

Completed

Be

Certification: To

Medical

State Registrar

physician

death certificate be executed

Box 68760,

Ö

۵.

Division of Vital Records,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 9 Unknown

Immediate Cause (Final

disease or condition resulting in death)

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

26. Place of Death (Check only

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of gleath?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown

death?

24b. Were autopsy findings available prior to completion of cause of

Year

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 1 Yes 2

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28h Time of 5 Pending investigation

sing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 No

Other:

28f. Location (Street and Number or Rural Route Number, City or Town, State)

24a. Was an

1 ☐ Yes

autopsy perforp

28d. Describe how injury occurred

29a. Certifier

27. Manner of Data latural Accident

3 Suicide

4 Homicide

1 C rtifying Physician: To the set of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 M dt = x x m n r: On the asis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) nd manner stated.

29b. Signature and title of certific

6 ☐ Could not be

determined

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

2

	51 01		Decedent's Name (First, Middle, Last)				2. Date of De		Year	3. Time of Death
	Physicia /Medic		ALONZO K. NELSON	,	JR.	October 19, 20		2010	4:20 P M	
	Examin		4a. Facility Name (If not institution, give street end number)			r Location of Death		4c. County of Death		
			Alice Byrd Tawes Nursing Home	Crisfield			Somerse			
	Funeral		5. Social Security Number 6. Sex 7. Age (<i>In yrs. last bin</i> 215−26−7345 1X M 2□ F 87	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	y, Year)	Cour	
	Director		Usual Residence of Decedent		02/15/	1929	Mary	land		
	land bw st		10a. State 10b. County 10c. City, Tow	n or Lo	cation				1	0d. Inside City Limits
	Mary -f sh fied a	to	Maryland Somerset	Cr	isfield					1 ☐ Yes 2 No
	r 28a r noti	irec	10e. Street and Number		10f. Zip Code			10g. Citize	n of What Cour	ntry?
	h witl	a D	3385 Sackertown Road			21817			U.S.A.	
	filed within 72 hours after death with the Maryland Hygiene, Hyariens in them 23a or 28a-f show ther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of H	lispanic Origin? (Sp	ecify Yes or No	- 14	Race - Americ	
9	or its		1 □ Never Married 2 □ XMarried 1 □ X es 2 □ No 1951 If Yes, Give		1 ☐ Yes 2 👿 No	Specify:			Specify: Whit	
Š	ural";	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1958							
Ď	"nat	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of work	ing	16b. Kind	of Business/In	dustry
7	withir ene. than he M	Ĕ	Elementary/Secondary (0-12) College (1-4or 5+)	ler		<i>-1</i> /		II.S	Posta	l Service
ב כ	filed Hygi sther		17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle,			T DELVICE
0	d be ental ked o	To Be	Alonzo K. Nelson			Erma L	awson			
<u> </u>	should nd Mer marke umatic	-	19a. Informant's Name/Relationship (Type. Print) 19b	. Mailir	ng Address (Street	and Number or Rui	ral Route Numb	er, City or 1	Town, State, Zip	Code)
Š	and 2 ealth a n 27 is er trai		Eleanor Nelson (Wife)	338	5 Sackert	own Road	- Crisi	field	, MD 2	1817
י ע	is 1 a		20a. Method of Disposition 20b. Place o	f Dispo	sition (Name of matory or other place		Date		ation - City or To	
	Pages nent of int: If its		1 X Burial 2 Li Cremation 3 Li Hemoval from State		Cemetery	· · · · · · · · · · · · · · · · · · ·	2/2010	Cris	field,	MD
֝֟֟֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Butterly, or items 23a or 28a-f show important: If them 27 is marked other than "natural; or items 20a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature Dune al Service Lice See		2. Name and Addre		3			
۵	8 8 E 8		Robert H. Bradshaw, Jr.	3	radshaw & 06 W. Mai	n StCr	neral Ho isfield	ome , MD	21817	
	STREET, STREET		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.			ng, such as cardiac	or respiratory a	rrest,	1	Approximate Interval Between
F	Physician	N.C. 1	Immediate Cause (Final disease or condition	w	- from	PUSS76	se le	usen	my)	Onset and Death
	/Medical		resulting in death) Due to (or as(a consequence	of):						
	Examiner	_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence							
	ed sit	Examiner	cause. Enter Underlying	01):						
	xecut and II-tran	xan	Cause (Disease or injury that initiated events c	of):						
ס	be e sician buria			,						
00	eath certificate be executed attending physician and for use as the burial-transit	an/Medical	d							
5	n cert ending use a	M/I	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy	۰.	75.4			23	d. Date of deliv	ery
ם :	deatl		in the past 12 months? 1 □ Yes 2 □ No		Other (specify)	/			Month	Day Year
2	at the by th tache	Physic	9 ☐ Unknown 9 ☐ Unknown							
່ກິ	es tha	by F	Part II. Other significant conditions contributing to death but not resulting in	n the u	nderlying cause give	en in Part I.	23e. Did t	obacco use	/	he cause of death?
5	equir en si ould h	led					1 🗆 '	Yes 2,	No 3□ Prol	pabły 4 □Unknown
. מ	as be	plei					24a. Was			opsy findings available
ב ו	The ate h page	Completed					perfo	rmed?	death? 1 ☐ Yes	21 No
1	cian; ertific ctor,	Be (25. Was case referred to medical examiner?			26. Place of Deat	th (Check only o	ne)		
	hysic this o	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou			4 Vursing no	ome 5 Resid			(y)
	Ing P	on:	1, Natural 5 Pending (Month, Day Year)	Time o	Wor		28d. Describe I	how injury	occurred	
	tend leath. tor: / the f	cati	2 Accident investigation 3 Suicide 6 Could not be 28e Place of injury. At home fa			Yes 2 No				
2	or Ai after of Direction by	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury - At home, fa building, etc. (Specify)	urn, Su	eet, ractory, office		City or Tol	vn, State)	Number or Hur	al Route Number,
1	pital ours a neral filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge	e. deat	h occurred at the tir	me date and place	and due to the	Called(s) a	ind manner as s	tated
:	To the Nospital or Attending Physician: The law requires that the der within 24 hours after death. Within 24 hours after death. Completely filled in by the funeral director, page 2 should be detached to completely filled in by the funeral director.	Medical	(Check only one) 2 Medical Examiner: On the basis of examination are and manner stated.	nd/or in	vestigation, in my o	opinion, death occu	rred at the time,	date and p	place, and due t	o the cause(s)
	vithin Forth	Me	29b. Signature and title of certifier		29c. Licens	e number		29d. Date	signed (Month,	Day(Year)
ì			1/1/2 M		12	3981	2	10	120	110
11	A .		30. Name and address of person who completed cause of death (Item 23a)	(Type,	Print)	4	7-	20		2
V	5*1		MATKINS My 201	U	will key	honory C	Kustine	let n	20 8	1817
	Sta		31. Date filed (Month, Day Year) OCT 21 2010 32. Figistrar's Signature	- 1	1					
	Registr	ar	WI HA WILL CENTRA B.	19	and					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ VIRGINIA M. OLSON OCTOBER 18 2010 Medical 1:33 A 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days (Month, Day, Y 1 □ M 2 🕱 F Hours **Director** 87 049-12-7516 1923 MASSACHUSETTS Usual Residence of Decedent show 10a. State be filed within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1

√
P Yes 2 □ No MD ANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7101 BAY FRONT DRIVE #519 21403 Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🕱 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: Specify: WHITE Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 4 LAB TECHNICIAN **EDUCATION** event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. GEORGE YOUNG traumatic ALICE SIMONSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DR. JOYCE Y. PASSOS/SISTER 1783 FOREST DRIVE #302 ANNAPOLIS, MD 21401 Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 😿 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CTR. 10/20/2010 STEVENSVILLE, MD 21. Signature of Funeral Service Lio 22. Name and Address of Facility FELLOWS HE CREMATION AND FUNERAL CARE 814 BESTGATE RD. ANNAPOLIS HELFENBEIN & NEWNAM 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure dist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ orebr disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any hading he immediate cause. Enter Underlying Examiner Due to (or as a consequente of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. certificate has been signed irector, page 2 should be det 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ → 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No ျ 1 → patient 2 □ ER/Outpatient 3 □ DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? S after oc. Seral Director, A: Afilled in by thr 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) 24 hours a Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 7 only one 1032176 29b. Signature and tit 10/18/21/0

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of

31. Date filed (Month.

erson who completed cause

of death (Item 23a) (Type, Print)

istrar's Signature

Drive Cherter Mis 2/6/9

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle | ast) 2. Date of Death Physician/ Leon Lawrence Petite Jr. October 18. 2010 1600 hrs[№] Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3420 Rickey Avenue; Apt. Temple Hills Prince Georges 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 D F Months Days Hours 578-46-7126 Director 76 1934 Washington, D.C. July Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Maryland Prince Georges Temple Hills 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Funeral 72 hours after death with 3420 Rickey Avenue; Apt. 242 20748 United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: **Black** 3 Widowed 4 X Divorced Specify: Completed Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working National Capitol life. DO NOT use retired) 12th grade mentary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien Supervisor/Maintenance Crew Housing Authority Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lawrence Petite, Sr. Mary Lewis 19a. Informant's Name/Relationship (Type, Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4449 "B" Street, S.E.; Washington, D.C. 20019 Joan Yvonne Smith-Woods 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 Oct.28,2010 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) National Harmony Memorial Park Landover, Maryland 21 Signature of Juneral Service 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.; 600 Kennedy Street, N.W.; Washington, D.C. 2001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Dilated Cardiomyopathy disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, Divi to for as a nonsequence of if any leading to immedicause. Enter Underlying Examin Cause (Disease or iinjury that initiated events that the death certificate be executed and tran Due to (or as a consequence of) resulting in death) Last g physician a Physician/Medical P.O. Box 68760 iding p IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year Yes 2 No g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed Diabetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? Cerebrovascular Accident 24a. Was an or Attending Physician: The law page 2 performe Hypertension Yes 2 X No 2 🗌 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) xaminer? Hospital 1 Yes 2 🗶 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred X Natural 5 Pending injury Accident
Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 7/2009

State Registrar (Check

29b. Signature and title of certifier

Basirmohmad F

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kolia, M.D.

32. Regis

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0028035

Clinton, Maryland

9135 Piscataway Road; Suite 310

29d. Date signed (Month. Day, Year)

October 21, 2010

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1258 Jeff Parker ctobe Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore City If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F August 19,1927 Hours 83 Director Louisiana 435-30-2044 Usual Residence of Deceden show 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland **Baltimore** 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21218 1012 Argonne Drive United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, rmed Forces?
X Yes 2 No Black, White, etc. 1 Never Married 2 X Married Completed by **Black** 1 ☐ Yes 2 X No Specify: If Yes, Give "natural", 3 Divorced 4 Divorced Year or Dates event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 years Physician Medical and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Edmond Parker Stella Randa11 Mary 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Odessa Brantley Parker 1012 Argonne Drive; Baltimore, Maryland 21218 more. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 8, 2010 Nov. 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Garrison Forest Vet. Cem. Owings Mills, Maryland)<u>#</u> Signature Funeral Service Licensee 22. Name and Address of Facility R. N. Horton Company Morticians, succe Inc.;600 Kennedy Street, N.W.; Washington, D.C. 2001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 No be detached 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Jas page 2 autopsy perform certificate within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, to Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗀 No 1 Inpatient 2 KRNOutpatient 3 IDOA မ Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 \square Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) OCTOBER 17, 2010 30. Name and address of person completed cause of death (Item 23a) (Type, Print) KERITH JOSE O.M BALTIMORE, MD 2,239 5601 LOCH RAVEN BLVD 31. Date filed (Month, Day, Year, State OCT 2 5 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep		, ,		
			Registrar	ertificate of Death	Re	g. No. 0 0 34867	
	Physicia		1. Decedent's Name (First, Middle, Last) WILLIAM RUTHERFORD PALMER JR.		2. Date of Death Month 10/18/2		
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	10/18/2	2010 10:22 P M 4c. County of Death	
19.00	Exami		1905 OWENS ROAD	OXON HILL		PRINCE GEORGE'S	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	9. Birthplace (State or Foreign	
	Director		234-50-8340 75 Yrs. Usual Residence of Decedent		6/25/193	Bluefield, WV	
	land show	ρ	10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits	
	Mary 28a-f otifie	Director	Maryland Prince George's Oxon Hi	11		1 🛚 Yes 2 🗌 No	
	ith the 3a or 1 be r	ra D	10e. Street and Number	10f. Zip Code		0g. Citizen of What Country?	
	ems 2	Funeral	1905 Owens Road 11. Marital Status 12. Was Decedent Ever in U.S. 13	20745 Was Decedent of Hispanic Origin? (Spe		JSA 14. Race - American Indian,	
9	ter de , or it amine	by F	1 ☐ Never Married 2 🔀 Married Armed Forces? 1 ☐ X Yes 2 ☐ No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.	
9	e filed within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ted	3 Widowed 4 Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 🛣 No Specify:		Specify: Black	
15	72 hc n "na Nedic	Completed	(Specify only highest grade completed) (Givi	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ing 1	6b. Kind of Business Industry	
212	within giene. i er tha		College (1-4 or 5+)	nical Psychologist		DC Government	
nd	filed wit tal Hygie d other event, th	To Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Ma		
ryla	2 should be file th and Mental H ?7 is marked o traumatic eve	-	William R. Palmer Sr.		Poindext		
Ma	··· = 0 .			ing Address (Street and Number or Rura			
Baltimore, Maryland 21215-0036	1 and of Heal item		20a. Method of Disposition 20b. Place of Disp			"Y Land 20/45 Oc. Location - City or Town, State	
imo	Page 1 nent of ant: If it ary or o		The same and the s	Memorial 11/1	/2010 T	andover, Maryland	
3alt	permit. Page 1: Department of I Important: If it any injury or of			2. Name and Address of Facility Pol		1 Homes, P.A.	
_						11e, Maryland 20747	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. Ust only one cause on each line. Immediate Cause (Final	ter the mode of dying, such as cardiac c	r respiratory arrest	Approximate Interval Between Onset and Death	
7	Medical		disease or condition resulting in death) CANCER PROSTATE Due to (or as a consequence of):			YEAR	
	Examiner	Ĺ	Sequentially list conditions, b.				
	si ti	dical Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying				
	ecute and Il-trans	Exar	Cause (Disease or illipory that initiated events c				
09	ate be executed obysician and the burial-transit	ical	d				
876	tificate ng phy as the	Med	IF FEMALE:				
Box 687	eath certifice attending p	ian/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3	Ectopic pregnancy		23d. Date of delivery	
ĕ.	ne dea y the a ched f	Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 g ☐ Unknown	Other (specify)		Month Day Year	
P.O.	requires that the der been signed by the should be detached	by Pi	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?	
ds,	quires en sig ould b	ted I			1 ☐ Yes	2 X No 3 Probably 4 Unknown	
COL	law re nas be e 2 sho	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of	
Be	Physician: The lav r this certificate has aral director, page 2		25. Was case referred to medical		performe 1 Ves 2		
/ita	/sicial	To Be	examiner? 1 Yes 2 No	26. Place of Death (Check			
of	ng Phy ter this	te: T	27. Manner of Death 28a. Date of injury 28b. Time of		28d. Describe how	ce 6 Other (Specify) injury occurred	
<u>o</u>	tendir Jeath. Ior: Af the fu	Certificate:	2 Accident Investigation	M 1 Tes 2 No			
Division of Vital Records,	il or Attend after death Director: A d in by the f	Ser	4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)	
	ospita hours meral d fillec	edical	29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death	occured at the time, date and place, and	due to the cause((s) and manner as stated.	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	≥	(Check 2 ☐ Medical Examiner: On the basis of examination and/or inveronly one) 3 ☐ Certifying Nurse Practioner: To neapest of my knowledge,	stigation, in my opinion, death occurred at death occurred at the time, date and place	the time, date and p e, and due to the ca	olace, and due to the cause(s) and manner stated. use(s) and manner as stated.	
	vit vit		29b. Signature and title of certifier	29c. License number		I. Date signed (Month, Day, Year)	
			30. Name and address of person who completed cause of death (Item 23a) (Type,	D 21438		October 20, 2010	
	5		Dr. Michael La Plenta 445 Defense H	ighway Annapolis, I	Maryland	21401	
	Stat	е	31. Date filed (Month, Day Year) 32. Registrate Signature		<i>y</i> =		
	Registra	r	and the same beautiful to the				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ HOLLAND O BOOK nnp Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S 12711 MARQUETTE LANE BOWIE 5. Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □XF Months Days Hours Min october Director 038-36-0726 53 19\$6 RHODE ISLAND Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "--- any injury or other *--or items 23a or 28a-f show 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No MD PRINCE GEORGE'S BOWIE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 12711 MARQUETTE LANE 20715 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give 1 Yes 2 No Specify. Specify: BLACK 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HAIR DRESSER PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည LLOYD E. PACK SR. BARBARA H. CARDOZA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LISA PACK/SISTER 896 JUNIPER STREET E. PROVIDENCE, RHODE ISLAND 02914 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State LANDOVER, MARYLAND 4 Donation 5 Other (Specify) HARMONY CEMETERY 10-25-10 21. Signature of Funeral Service J. B. JENKINS FUNERAL HOME, INC. 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter Me disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) 3 Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence or): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Day Pregnant at time of death Month Year signed by the a Id be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy perform 1 Tes 2X No Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 2 No Other: 1 🗌 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury Investigation 1 Yes 2 🗌 No after death filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined 24 hours a Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifie 29c. License number

State Registrar DHMH 17 Rev 7/2009 30. Nam

and address of person

5 2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October Clinton Woodward Phillips 2010 11:1.0A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's <u> Renaissance Gardens</u> - Riderwood Silver Spring 8. Date of Birth (Month, Day,) April 24 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Months Days Hours Min. 1919 Washington. Director 577-09-0260 91 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits the Maryland Director 1 Yes 2 X No Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 72 hours after death with 3116 Gracefield Road. 20904 Apt.u.s.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11, Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. ģ 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 X No Specify. If Yes, Give Year or Dates Specify 3 Uvidowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) be filed within and Mental Hygiene. Mechanical Engineer U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Harry Clinton Phillips Bessie Ellen Woodward permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20904 Apt. #218, Silver Spring, Mary Jane Phillips - Spouse 3116 Gracefield Road. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) George Washington Cem 10/23/2010 Adelphi, Maryland 21. Signature of Funeral Service Licen. ee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, MO #1070 11800 New Hampshire Ave., Silver Spring, MD 20904 se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part 1. Enter the dise shock, or heart failure Approximate Interval Between Immediate Cause (Final Physician Unknown Congestive Heart Failure disease or condition Medical resulting in death) **Examiner** Unknown <u>Ischemic Heart Disease</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or) burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death for use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Hupertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🏌 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of Anemia 24a. Was an has autopsy death? this certificate Yes hours after death.

Ineral Director: After this certific

d filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be 1 🗌 Yes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State within 24 hours a Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. npleted (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eileen Gemmell. CRNP, 3160 Gracefield Road, Silver Spring, Maryland 20904

State

Registrar

31. Date filed (Month, Day, Year,

OCT 21 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra AMEND#23e, perMD, 10/22/10, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Nedra Mary Patrick October 18. 2010 ear 5:30 Р Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery 5555 Friendship Blvd. #403 Chevy Chase 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XE Months Days Hours 06/29/1923 Yrs. Maryland Director 219-14-6122 87 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location death with the Maryland notified at 10d. Inside City Limits Director 1X Yes 2 No Chevy Chase Montgomery Md 0 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral 20815 U S 5555 Friendship Blvd # 403 "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. à 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced Completed 10/1946 Year or Dates White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.

27 is marked other than '
traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) 4 Registered Nurse Medicine Be filed 17. Father's Name (First, Middle, Last) Charles 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental fitem 27 is marked ည Newton Dawson Jr Lista Beemiller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard G. Patrick / Husband 5555 Friendship Blvd. #403 Chevy Chase, Md 20815 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or ot 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 10/21/10 National Crematory Falls Church, 21. Signature of Funeral Service Lic 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 23a, Part 1. Enter the disease, or complications that of used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure List only one cause on ea Immediate Cause (Final Onset and Death Physician/ Malnutrition disease or condition year Medical resulting in death) Due to (or as a consequence of) Examiner Alzheimers Disease 4 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician; The law requires that the death certificate be exented burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death Month Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s SBL autopsy perform certificate Yes 2 X No 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🔼 No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 K Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral (27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical 29a. Certifier 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the Desit of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the Desit of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one the 29b. Signature 29d. Date signed (Month, Day, Year) ρ 10 10 9

Registrar

DHMH 17 Rev 7/2009

State

5530 Wisconsin Ave. Suite 700 Chevy Chase, Md 20815

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Allen A. Nimetz, MD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) for State Registrar Certificate of Death 1. Desedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month / 0 Physician/ A220 0030 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign
Country) **Funeral** (Month, Day, Country)
New Jersey 1 □ M 2 🗗 F Months Days Min. Hours Yrs. 85 Director 146-54-7883 Jan. Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3710 Excalibur Ct., Apt. 102 20716 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc injury or other traumatic event, the Medical Examin e. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. Specify 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) N/A Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishership ဂ John Palazzo Antoinette Manno permit. Page 1 and 2 should t Department of Health and Me Important: If Item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grace P. Vicino / Sister 3710 Excalibur Ct., Apt. 102, 20716 Bowie, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Calvary Cemetery 10/19/2010 Cherry Hill, NJ 4 Donation 5 Other (Specify) 22. Name and Address of Facility Beall Funeral Home Signature of Funeral Service Licensee any 6512 NW Crain Hwy., Bowie, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ DON IRA 4 MONIA disease or condition Medical resulting in death) Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) sician and burial-transit Exami The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes 2-No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 Tyes Hospital or Attending Physician: 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 \(\text{Yes} 2 No မ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 1 Natural 28b. Time of 28c. Injury at 5 Pending work? 1 ☐ Yes 2 ☐ No n 24 hours after death.

e Funeral Director: Aft bleted filled in by the fur ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifie 1)21438 30. Name and address of person who pompleted cause of death (Item 23a) (Type, Print) ANNAPOLIS MAZIKUI DEFENSE HWY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O.

Records,

Division of Vital

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 9:55 P. M Quattlebaum October 18, 2010 Harold /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Gladys Spellman Specialty Hospital Chever1v If Under 1 Year | Il Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye April 2, 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** , 1937 South Carolina Days 1 XM 2 ☐ F 73 Yrs. 577-50-3756 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatht and Mental Hygiene. Int: If them 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 27 Is marked other than "natural", or Itsms 23a or 28a-f show traumatic syste, the Medical Examiner must be notified at District of Columbia Washington 1 X Yes 2 No Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20020 United States 2641 Naylor Road; S.E.; Apt. 204 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black þ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry mentary/Secondary (0-12) College (1-4or 5+) Mail Clerk Heritage Foundation 9th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Onnie Quattlebaum Lucille Green 9 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Therest Irene Segears (Daughter) 6504 Parkwood Street; Hyattsville, Maryland 20784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Nov.1,2010 1 ☐ Burial 2 XCremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Riverdale Park Crematory 4 ☐ Donation 5 ☐ Other (Specify) Riverdale, Maryland 21. Signature of Funeral Service Licerisee 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C.20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Septicemia /Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of) the attending physician a hed for use as the burial-Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) signed by the a Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Respiratory Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 24 No certificate 1 Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2XNo 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural 5 Pending 1 Yes 2 No 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Medical 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number D0026024 October 21, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lester Miles, M.D.; 1160 Varnum Street, N.E.; Ofc: 306; Washington, D.C. 20017 State Registrar

DHMH 17 Rev 1/2001

Certificate of Death

Box 68760, ۵. Division of Vital Records, cate has page 2 s

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 4:20 am Marilyn Ann RUDOW 23, October 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1810 Brightwood Drive Hagerstown Washington If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
April 8,1934 Birthplace (State or Foreign Country) **Funeral** Hours Months Days Director 511-30-3339 Kansas Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show the Medical Exerterer must be notified at Director 1 ☐ Yes 2X No Maryland | Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1810 Brightwood Drive 21740 U.S.A. by Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married permit. Pages 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or lany injury or other traumatic accounts. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No white Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12 \end{array}$ College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernst Meyer Norma Belle Mulvaney ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald R. Rudow - husband 1810 Brightwood Drive, Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hagerstown Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State October 27, 2010 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ENDOMETRIAL CANCER **Physician** FARS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 🗌 Yes 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performe 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check hly one) Other: 4 Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA S Residence 6 □ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28d. Describe how injury occurred 1/ Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No s after death.

I Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aff

To the Funeral Di

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my animal death. 29a. Certifier Medical (Check only one) Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signatur 29c. License number D0056783 e of death (Item 23a) (Type, Print) 30. Name Medical Campus Ste 130 Hagerstown MD 21742 01-10 31. Date filed (Month, Day, Year) State 25 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ RICHARDSON 20 .55 AM CALISTA Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Loyalton Assisted Living Washington Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, 1 🗆 M 2 Months Davs Hours Min. **Director** 76 Mary1and 214-32-3991 Dec. Usual Residence of Decedent show 10a. State 10b. County ıral", or items 23a or 28a-f sho | Examiner must be notified at 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director 1 Yes 2X No MDWashington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2009 Rosebank Way #109 21742 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc 1 Never Married 2 X Married Š ☐ Yes 2 🔀 No hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White "natural" Completed 3 Widowed 4 Divorced Medical Decedent's Education 16a. Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 i Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event **-16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Gertrude E. Gladhill Glenn Elliott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donnie Richardson/Bro-In-Law 12215 West Lawn Lane, Hagerstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 10/25/2010 | Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 5 Man K 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury ig physician and as the burial-transit ARCINOMA Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death asn 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Day Year should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has ral director, page 2 s performed Yes 2 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 1400 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21742

DHMH 17 Rev 7/2009

State Registrar Ian H. Newbold,

31. Date filed (Month, Day, Year)

MD

19426 Leitersburg Pike, Hagerstown,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ LEY ANT 2152M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1*0%25/*34924 220-16-7379 85 Marvland **Director** Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 805 Coxswain Way, #105 21401 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, rmed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 1943-46 Year or Dates. Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) 2 should be filed within 72 hand Mental Hygiene. 7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) Chiropractor Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Travis Roland Riley Anna Ellen Mankin 19a. Informant's Name/Relationship (Type, Print)
William Mitchell/Personal Rep. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 410 Rowe Blvd., Annapolis, MD 21401 permit. Page 1 and 2 sh Department of Health a Important: If item 27 is or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Kalas Crematory 1 Burial 2 X Cremation 3 Removal from State Edgewater, Maryland injury o 4 ☐ Donation 5 ☐ Other (Specify) 10/19/10 ice Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on Immediate Cause (Final and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death signed by the a g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , page 2 performed 1 Yes 2 No Be 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) lospital. 1 🗆 Yes 2 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

only one) 29b. Signature and title of certifie

OCT

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Holland James Scott Jr. 10 Medical 1102 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death PAIDNAL Womics ial Security Numbe 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Virs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 525-92-4672 1 X M 2 🗆 F Days Hours Virginia 84 Director Yrs 09/23/1926 Usual Residence of Decedent or 28a-f show e notified at within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits Virginia Accomack Onancock 1 ื Yes 2 🗌 No 10e. Street and Number 10f. Zip Code must be 10g. Citizen of What Country? Funeral 23a 1 Merry Lane 23417 USA ıral", or items 2 Examiner mus 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?

X Yes 2 \(\sum \) No Completed by 1 Never Married 2 K Married Maryland 21215-0036 If Yes, Give Year or Dates. Army 1 ☐ Yes 2 X No Specify: "natural", 3 Divorced white traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other transmitted." Elementary/Seconday (0-12) College (1-4 or 5+) engineering technician government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 James Holland Scott Sara Temple Segar 19a. Informant's Name/Relationship (Type, Print) . Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Merry Lane, Onancock, VA 23417 Jean T. Scott/spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Donation 5 Other (Specify) Shore Crematory 10/18/2010 Parksley, VA 21. Signature of Funeral Pervice 22. Name and Address of Facility HOLLOWAY Funeral Home Professional Association Domoson 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Physician/ Intracremed Henomage disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner FAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events 24 ms Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day Yes 2 No 1 ☐ Yes ∠ p g ☐ Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig page 2 should b 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? After this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 욘 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) o the Funeral Director; After thi ompleted filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury ☐ Natural 5 Pending 2 X Accident 3 Suicide Lost Balance 1057 am 1 Tyes 2 **X** No Investigation walking up steps 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number City or Town, State) 4 Homicide Rural Route Number. determined building, etc. (Specify) hurch 75 *Market* Orancock VA Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature ag 29d. Date signed (Month, Day, Year) 450457 10/18/10 057331 30. Name and address of person who com eath (Item 23a) (Type, Print) 100 Last Carrol Mis bury 31. Date filed (Month, Day, State Registrar's Signature Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			nt's Education est grade completed) College (1-4	or 5+)	(Give F	lent's Usual Oct sind of work don O NOT use retin	ne durina m	ost of work	ing	16b. Kir	od of Business	
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Medical Examiner		resulting in death)	Due to (or My	consec	quence of):	nfact						15days
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10		30 Name of address of second	who completed sever	f death /ltc-	m 23a) /Time P	int)	587	<u> </u>		Oct	ober 18	3,2010
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State Registrar DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ Rita M. Solomon 0350 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Adventist Hospita montgomery Rockville If Under 1 Year | If Under 24 Hrs curity Number 12 9429 7. Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 376 1 □ M 2 🎛 F Months April 1 3, 1918 Hours Michigan Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Gaithersburg MD 1 😾 Yes 2 🗆 No 10e. Street and Number 10f. Zip Code 20879 10g. Citizen of What Country? by Funeral 405 Christopher Ave. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 No 21215-0036 1 ☐ Yes 2 A No Specify: Specify:White 3 ₩ Widowed 4 Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Medical Research Secretary 11th Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Grenier Beulah Knoggs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Monica Solomon/ Daughter 11300 Rambling Rd. Gaithersburg, MD 20879 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Chesapeake Crem. 10/21/2010 Beltsville,MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility Cedell Brooks Funeral Home 25662 A.P. Hill Blvd.Port Royal, VA22535 1 < 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failured ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Colon Physician/ Metastatic disease or condition resulting in death) Jeek Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death signed by the a 4 ☐ Pregnam 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 40 thrise 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen Fibrilladion 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy
performed?

Yes 2 No has nis certificate h I director, page Gastrointestinal 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 \(\triangle \text{ Nursing Home } 5 \) Residence 6 \(\triangle \text{ Other (Specify)} \) Hospital ဂ္ 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) hin 24 hours after death. the Funeral Director: After thi upleted filled in by the funeral Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Deducat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of certi 29c. License number 29d. Date signed (Month, Day, Year) October 20,2010 D0064413 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville MD Smith medical Ctr. Dr. Juanita 9901 MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 19, 2010 Year A^{M} Geraldine 6:21 Smith Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 4307 Lucerne Road Temple Hills Prince George's Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** 1 🗆 M 2 🔀 F Months (Month, Day, Year) North Carolina **Director** 243-96-5295 55 Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 X Yes 2 No Maryland | Prince George's Temple Hills 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? pe Funeral er than "natural", or items 23a the Medical Examiner must b 20748 United States 4307 Lucerne Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: If Yes Give Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Program Assistant Private Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic evem 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Augustus Lee Smith Mary Elizabeth Brantley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeremaine A. Smith - Son 7805 Beddington Court Clinton, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or Brantley 1 X Burial 2 Cremation 3 Removal from State ober Tillery, North Carolina Plot 4 Donation 5 Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service Licenses Benning Road NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Arterosclerotic Hypertensive Heart Disease Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Onknown Month Day 5 Other (specify) Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has page 2 performed 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) æ examinera Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at s after death. I Director: After t 28d. Describe how injury occurred Natural 5 Pending Accident 1 Yes 2 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Hospital within 24 hours

To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 200

State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31 Date filed (Month, Day, Year)

OCT 2 5 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. Ne. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month SU DING SHUEH - ZHANG : 45 PM 2310 OCT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Itowars ITUWALD COUNTY GENERAL MORPITAL COUMBIA Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F Months May 24, 1926 Country) China Director 213-23-3230 Usual Residence of Decedent show 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Derentment of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at one. 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🗓 No Columbia Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21044 U.S.A. 5755 Cedar Lane Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify. Asian 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (Unknown) Zhang (Unknown) Chang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4507 Haywagon Way, Ellicott City, Maryland 21043 Michael Xue - Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🔀 Removal from State National Memorial Pk. 10/23/2010 | Falls Church, VA 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home. M00709 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Fart 1. Enter the risease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final AWTE RESPIRATING Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner PNEUMMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine the attending physician and the for use as the bunal-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 5 Other (specify) been signed by the should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? COLINALLY NETARY DISEASE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown CRANCOPHARYNZEGAL DYSPINACIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has OGNENTIA 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 1 ☐ Yes 2 🕱 No 1 Conpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending injury 1 Natural 1 ☐ Yes 2 ☐ No. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Defining injection. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number

State Registrar 10710

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

an mathyra, a

31. Date filed (Month, Day, Year)

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CHARTER DR # 310 COLUMBIA

15, 2010

21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ October 13, 2010 4:50 Scott Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Health & Rehab Bethesda Bethesda 9. Birthplace (State or Foreign Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Social Security Number 577-28-7620 **Funeral** 1 □ M 2 🗓 F Months Days 3-10-1924 Unknown Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c, City, Town or Location Bethesda 10d. Inside City Limits Director Montgomery 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20814 5721 Grosvenor Lane hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. should be filed within 72 hours after d and Mental Hygiene. is marked other than "natural", or i 1 Never Married 2 Married þ Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 → Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private Secretary Be Mother's Name (First, Middle, Maiden Surname) Unknown 17. Father's Name (First, Middle, Last) Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Chevy Chase, MD 20815 6908 Connecticut Ave. (Friend) John Kavanagh Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 Disposition 3 Removal from State 20c. Location - City or Town, State Fort Lincoln Cemetery 10/27/2010 Brentwood, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funer Service Licensee 3401 Bladensburg Road Brentwood, MD 20722 of whit promisso Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) IVE HEART FAILURE **Examiner** Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last burial-1 attending physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Year Pregnant at time of death the cate has been signed by a page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law r 24 hours after death.
 Funeral Director: After this certificate has b performed? 1 Yes 2 No 1 🗌 Yes 2 🖼 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 40 Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number

CR 3

State Registrar 10110 Molecular Dr. Suite 206 Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Truong Bao, MD
31. Date filed (Month, Day, Year)

OCT 2 1 2010

soo, MD

00057124

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 6:00 PM **Physician** 3010 mmon /Medical 4a. Eacility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner CO If Under 24 Hrs. 8. Date of Birth Month, Day, Under 1 Year 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthda) 6. Sex **Funeral** Days Hours 1 ☐ M 2 🗓 F 13 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State item 27 is marked other then "natural", or items 23a or 28e-f show other treumstic event, Ite Madical Execution in items for invitiled at 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code deeth with Was Decedent Ever in U.S. Armed Forces? by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 12 Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other then "natural", or ite ☐ Yes 2) No Yes, Give 1 Never Married 2 Married 1 🗌 Yes 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify If Yes, Give Year or Dates: 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most life. DO NOT use retired) Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mother's Name (First, Middle, Famer's Name First, Middle. Be ationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code, Informant's Name/Re Depertment of Health a Important: If item 27 is any injury or other tree Once. 20a. Method ol Disposition Place of Disposition (Name of Date Location - City or Town Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart laikure. List only one cause on each line. Approximate Interval Between Onset and Death such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner resh, Sequentially list conditions, if any, bearing to instructions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Examiner use as the burial-transit The law requires that the death certificate be executed vener Due to (or as a consequence of) the attending physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.0. be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 Tes To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Diractor: After this certifica filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☐ 27 Manner of eath 1 Inpatient 2 2 ER/Outpatient 3 DOA 4 Nursing Home 5 esidence 6 Other (Specify) 2 d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 5 Pending investigation tural 1 ☐ Yes 2 ☐ No 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide Becrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifie Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and tifle of certifier 29c. License number ss of person who completed cause of death (Item 23a) (Type, Print) 305 10h 31. Date liled (Month egistrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER 2010 9:30 A M CHARLIE **JAMES** TORAIN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CHEVERLY If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days (Month, Day, Yea MARCH 28 1 X M 2 D F NORTH CAROLINA 1948 Director 241-80-1317 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10d. Inside City Limits 10b. County 10c, City, Town or Location death with the Maryland Director Yes 2 🗆 No PRINCE GEORGE'S UPPER MARLBORO 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral USA 20774 11401 HONEYSUCKLE COURT Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 12 Yes 2 No ARMY
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 within 72 hours after Specify: BLACK 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Divorced 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important if item 27 is marked other than 'any injury or other traumatic event, the Meany injury or other traumatic event, the Meany injury or other traumatic event, the Meany injury or other traumatic event, the Meany eines. Elementary/Seconday (0-12) College (1-4 or 5+) SUPERVISOR PRIVATE Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည POOLE EMMA WILLIE F. TORAIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11401 HONEYSUCKLE COURT UPPER MARLBORO, MARYLAND VERNIKA S. TORAIN/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Re CHELTENHAM, MARYLAND VETERANS CEMETERY 10/29/2010 4 ☐ Donation 5 ☐ Other (Specify) J. B. JENKINS FUNERAL HOME, INC. Signature of Euron of Sev ce I rensee 22. Name and Address of Facility ROAD HYATTSVILLE, MARYLAND LANDOVER disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. Approximate Interval Between Onset and Death Fart 1. Enter the c shock, or heart fai Immediate Cause (Final Physiciani disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and the burial-trar Due to (or as attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death sate has been signed by the a page 2 should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ₽ No 1 Yes certificate Yes 25. Was case referred to medical 26. Place of Death (Check only one) director Be examiner? Hospital: 1 Yes 2 🗌 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death Vatural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 5 \square Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signatu and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 28a) (Type, Print) Atras

Registrar DHMH 17 Rev 7/2009

State

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31. Date filed (Month, Day, Year)

5

rince

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

	Physician
	/Medical
	Examiner
-	

			For State Registrar	State of Marylar		rtificate of L			eg. Né.)	0 31.885
	Physici		Decedent's Name (First, Middle, Last) Barbara	Key Thompso	on			2. Date of Deat Month		3. Time of Death 10:17 A.
	/Medic Examin		4a. Facility Name (If not institution, give si			4b. City, Town, or	Location of Death	000000	4c. County of	
-			Fort Washington				Washingt			ce Georges
ı	Funeral Director		5/7-52-7099	7. Age (In yrs. 73	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Februar	Year 1937 9. Year 13, W	Birthplace (State or Foreign Country) ashington, D.C.
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	cation		-		10d. Inside City Limits
	Mary	tor	Maryland Charles	s	Waldo	rf				1 X Yes 2 ☐ No
	th the	Funeral Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wha	t Country?
	ath w	ral	2163 Pineview Cou			20601			United	
	er de items	-cu	- Trimanar Gadas	2. Was Decedent Ever in U Armed Forces?	.S. 13. \	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, Vhite, etc.
920	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23s or 28a-f show ant, I'm Medical Evan, her must be medified at	þ	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 █ No If Yes, Give Year or Dates:		1 □Yes 2 X No	Specify:		Specify:	Black
215-0036	72 hou	Completed	15. Decedent's Educi (Specify only highest grade	ation	16a. Dece	dent's Usual Occupa	ation	ina	16b. Kind of Busin	ess/Industry
21	be filed within 72 ho tal Hygiene. d other than "natul event, I'n volon	mple	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done of DO NOT use retired Omemaker)	ing	Do-	estic
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Maryland	be od c	To Be	Charles Key				Polli			
ary	s 1 and 2 should of Health and Mer Item 27 is marke other traumatic	-	19a. Informant's Name/Relationship (Typ	oe. Print)	19b. Mailir	ng Address (Street a	and Number or Rur	al Route Number	; City or Town, Sta	nte, Zip Code)
Σ,	and 2 ealth a n 27 is		Benjamin Thompson			Pineviev				
Baltimore,	그 그 그		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re	20b. femoval from State	Place of Dispo cemetery, crem	sition (Name of natory or other plac	e) Oct.2	27,2010	20c. Location - Cit	y or Town, State
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Ra	permit. Pag Department Important: any injury once.		21. Signature of Funeral Service Licensee	RHA	The second secon				_	ny Morticians, ngton,D.C.2001
ш	_		23a. Part 1. Enter the disease, or complic	cations that caused the deal						Approximate
and a	Physician		shock, or heart failure. List only one Immediate Cause (Final disease or condition	thun a	Uxc	emio	4			Onset and Death
	/Medical		resulting in death)	Die to (o) as a consec	uence of).	•	•			1 ()
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<u>,</u>	execu n and al-tra	Exar	that initiated events c. resulting in death) Last	Due to (or as a conseq	uence of):	1 6 0 00				11-01-11-10
98/90	rtificate be executed ng physician and as the burial-transit	Medical I	d.		,					
	ntifica ing ph	Medi	IF FEMALE:							
ROX	death cer e attendin id for use a	ian/I	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	aldéath 3∐	Ectopic pregnancy	/		23d. Date of Month	
	the de by the a sched f	Physician/	1 □Yes 2 X No 9 □ Unknown	4 ☐ Pregnant at time of e 9 ☐ Unknown	death 5	Other (specify)				24,
<u>.</u>	that ed t deta		Part II. Other significant conditions cont	tributing to death but not res	ulting in the ur	nderlying cause give	en in Part I.	23e. Did tob	acco use contribu	ite to the cause of death?
rds,	requires seen sign hould be	ed by	Systemu	lupu	٥			1 ☐ Ye	s 2 2 Ne/ 3[☐ Probably 4 ☐ Unknown
Hecord	law re as bee 2 sho	plet	0	1				24a. Was ar	n 24b. Wei	re autopsy findings available
_	l h	Completed						autops perforn 1 □Yes 2	nod? dea	r to completion of cause of th? Yes 2 □ No
VITA	Physician: The li	Be (25. Was case referred to medical examiner?				26. Place of Deat			
0	Physical this call dire	.To	1 ☐ Yes 2 No Ho		ER/Outpatier 28b. Time of		4 LI Nursing Ho		ence 6 Other	(Specify)
0	nding Physician: ith. : After this certifice s funeral director, p	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	Injury	Work	y at :? Yes 2 □No	28a. Describe no	w injury occurred	
DIVISION	after des Director d in by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Special	ome, farm, stre fy)	eet, factory, office		28f. Location (St. City or Town		or Rural Route Number,
	Io the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one) 1 Certifying Physi 2 Medical Examino	ician: To the best of my kno er: On the basis of examina and manner stated.	owledge, death ation and/or in	n occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the cred at the time, da	ause(s) and mann ate and place, and	er as stated. I due to the cause(s)
	Io the within To the соптр!	Me	29b. Signature and title of certifier	1	.1	29c. License			9d. Date signed (A	Month, Day, Year)
b.	-10		M.M.M	ub liam	, M)	4	6046)	0-21	-2010

State Registrar 31. Date filed (Month, Day, Year OCT 2 5 2010

DHMH 17 Rev 1/2001

Amir Mirza-Alikhani, M.D.; 11711 Livingston Road; Fort Washington, Maryland 20744

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Contober Day 21,2010 5:10 A Beth S. Tilley Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery 12812 Broadmore Road 8. Date of Birth (Month, Day, July 21, Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 📭 Days Hours Min. New Jersey 579-18-3423 91 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Examiner must be notified at Director Silver Spring 1 🗌 Yes 2 ื No Maryland Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? USA and Mental Hygiene. 20904 Funeral 12812 Broadmore Road 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married White 1 Yes 2 No Specify: Specify: Completed 3 Divorced 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Library of Congress 12 Accountant other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be file.
Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ဂ္ Gertrude Elmira Race Joseph Saunderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12812 Broadmore Road, Silver Spring, MD 20904 Norman N. Tilley/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of Oct. 25 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park 4 Donation 5 Other (Specify) 2010 Rockville, Maryland 21. Signature of Funeral Service Licensee Francis J Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death
5 yrs Immediate Cause (Final Physician/ disease or condition resulting in death) Bladder Cancer Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) physician and s the burial-transit Exami death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death signed by the at d be detached for 1 Yes 2 l Yes 2 X No 9 Unknown Part II. Other significant conditions contributing to death but not resulting In the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Malnutrition, Hyperetension, Dementia To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign agony perfector, page 2 should be 1 Tes 2x No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending ☐ Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)
October 21, 2010 d title of certifier 29b. Signature (C D18726 m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18111 Prince Philip Drive, Olney, MD 20832 Arthur Schoengold, MD 31. Date filed (Month, Day, State

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene?

\(\) 34887 Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Gilbert Ray Turpin October 17 ay 2010 Year 0041 Ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number 7. Age (In yrs. last birthday) 74 Yrs. If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Hours Min. 363 34 7659 1 🔀 M 2 🗆 F Director 02/25/1936 Mfchilgan Usual Residence of Decedent show 10b. County 10a. State filed within 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1XXYes 2 □ No IN Hamilton Fishers 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12063 Proper Pass 46037 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Completed 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Director of Science/Math Curriculum 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+)
5+ Public School System Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Claude McKee Turpin Ruth Evelyn Maple 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12063 Proper Pass/Fishers IN 46037 Gwendolyn McVeigh/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗆 Burial 2 🛭 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 10/18/10 Alexandria VA 21. Signature of Fyneral Service Licensee 22. Name and Address of Facility and Cremation Services > Mollewase Annapolis MD and Falls Church VA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ maria disease or condition Medical resulting in death) r as. Examiner ean. movas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Examin Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician; The law requires that the death certificate be executed and -tran Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death
Unknown Day Year signed by the ar 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 1 ☐ Yes 2 ☐ Ho 3 ☐ Probably 4 ☐ Unknown After this certificate has been situated funeral director, page 2 should 24a. Was an Were autopsy findings available prior to completion of cause of death? autopsy Yes 2 [1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 XINO Other: 1 🗌 Yes မ 1 Phopatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 4 hours after death.

-uneral Director, After this
ed filled in by the funeral d 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending injury work?
1 Yes 2 🗆 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours e Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check within 2 To the only one Certifying Nu Prac oner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29d. Date signed (Month, Day, Year) 10/17/2010 cause of death (Item 23a) (Type 30. Name and add 31. Date filed (Month

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER 14 2010 ar 12:45 Рм THOMAS DORIS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S CLINTON SOUTHERN MARYLAND HOSPITAL 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1 M 2 🖫 F JUNE 6 1932 WASHINGTON, DC **Director** 78 577-42-6361 Usual Residence of Decedent 23a or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature" any injury or other traus-10a. State 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 Yes 2 ☐ No LANDOVER MDPRINCE GEORGE'S 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2312 BRIGHTSEAT ROAD #4 20785 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married BLACK 1 ☐ Yes 2 X No Specify: If Yes, Give 3 - Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE BOOK BINDER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 LILLIAN E. BUSH JAMES W. THOMAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1722 BRIGHTSEAT ROAD #201 LANDOVER, MARYLAND 20785 DAUPHINE Y. MARCH/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/23/2010 WASHINGTON, DC GLENWOOD CEMETERY J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ SEPSIS disease or condition Medical resulting in death) **Examiner** INF ECTION URINARY TRACT Sequentially list conditions, If any, leading to innectate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a nonsequence on Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☒ No Month Day Year Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by BREAST CANCER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 🗆 No 2 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manny of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation after death 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Signature and title of certifier

State Registrar 7503

32. Regist ar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ONWUKA. MO

31. Date filed (Month, Day, Year)

D0064986

SURRATTI ROAD . CLINTON.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	•	State State Amend Item 2 pe	r dr.,g911,0	Certificate of I	b Death	Re	g. No.	34889
Physician		1. Decedent's Name (First, Middle, Last) Mozelle W. Wa	nner			2. Date of Death Month October	2010	3. Time of Death
Medica Examine		4a. Facility Name (if not institution, give street and	number)		r Location of Deatl		4c. County of Dea	
1		Williamsport Retire 5. Social Security Number 6. Sex			sport I If Under 24 Hrs.	To But the	Washir	
Funeral Director		173-20-0824 1 □ M 2X	7. Age (In yrs. last birth	rs. Months Days	Hours Min.	8. Date of Birth (Month, Day January 26	rear 1926 Penr	thplace (State or Foreign suntry) Sylvania
at trind	ō	Usual Residence of Decedent 10a, State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
Maryla 28a-f s otified	irect	Pennsylvania Allegheny	Pitts	burgh				Y Yes 2 □ No
s 23a or	Funeral Director	10e. Street and Number 5210 McAnulty Road		10f. Zip Code 15236		10	og. Citizen of What Co USA	ountry?
은 노름	þ	1 Never Married 2 Married 1 N	ecedent Ever in U.S. I Forces? les XX No Give r Dates.	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2√√ No	an, Mexican, Puert	oecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit Specify: Whi	e, etc.
15-0	Completed	15. Decedent's Education (Specify only highest grade comple	ted) (Decedent's Usual Occup Give kind of work done	ation during most of wor	king	6b. Kind of Business	Industry
212 within giene. er thar , the N		Elementary/Seconday (0-12) Colleg	e (1-4 or 5+)	ife. DO NOT use retired) Iousewife			Homemaki	ng
	To Be	17. Father's Name (First, Middle, Last) James Huffman				ne (First, Middle, Ma rine Re:		
		19a. Informant's Name/Relationship (Type, Print) Cheryl Cross (Da	aughter) 13	Mailing Address (Street 802 Windy I	and Number or Ru Hill Lane	ral Route Number, (City or Town, State, Zi	p Code) Land 21742
> - % E ?		20a. Method of Disposition 1 Department of Disposition 1 Department of Disposition S	rom State cemetery	Disposition (Name of crematory or other place			Oc. Location - City or	Town, State
Baltimo		21. Sig ature o Funeral Service lice/see	M-00849	22. Name and Addre	ss of Facility ofor Fune	eral Home	, Inc.	QII, PA 15256
	\dashv	23a. Part 1. Enter the disease, or complications the	nat caused the death. Do no	1 48 S. Cht ot enter the mode of dyin	arch Stre g, such as cardiac	et, Wayne or respiratory arres	esboro, PA	Approximate
Physician/ Medical		shock, or heart failure. List only one cause of Immediate Cause (Final disease or condition resulting in death)	Ischemi	c Carro	Liomyo	rathy		Interval Between Onset and Death
Examiner	.	Sequentially list conditions b.	to (or as a consequence of			.		
uted id	Examiner	If any, reading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events	to (or as a consequence of					
be e buria	edical Ex		to (or as a consequence of):				
68760 certificate b nding physiuse as the b	Med	IF FEMALE:						
BOX 6	Physician/M	in the past 12 months?	outcome of pregnancy ive Birth 2 Fetal death regnant at time of death Inknown	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	Sy .		23d. Date of de Month	livery Day Year
s that the gned by be detact	ል	Part II. Other significant conditions contributing	to death but not resulting in	the underlying cause gi	ven in Part I.		acco use contribute to	
rds require	eted	palmmary h	Myserung!	10V/ ,		1 ☐ Yes		robably 4 Unknown
Hecords, The law requires tate has been signage 2 should b	Completed	AT Mal fils	ulla ()			autopsy perform	prior to	completion of cause of
tal F	Re	25. Was case referred to medical examiner?		The state of the s	ace of Death (Chec		2110	S Z LINO
Sis consists of direction of the sister of t	으	T Yes 2 ANO 1	☐ Inpatient 2 ☐ ER/Out	- ·	4 Laursing H	ome 5 Residen	ce 6 Other (Spec	ify)
# g € E E E :		27. Manner of Death 28a. D	ate of injury 28b. Tit	ne of 128c. Injur			injury occurred	
tending Ph feath. tor: After th the funeral		1 Natural 5 Pending (A	flonth, Day, Year) inj	ury work M 1 □				
DIVISION Of VITAI tal or Attending Physician: rs after death. al Director: After this certificed in by the funeral director.	Certificate:	Natural 5 Pending Accident Investigation S Suicide 6 Could not be	ate of injury fonth, Day, Year) ace of Injury - At home, farm fillding, etc. (Specify)	ury work M 1 □	?		et and Number or Ru State)	ral Route Number,
DIVISION OF he Hospital or Attending Pr in 24 hours after death. he Funeral Director: After th pleted filled in by the funeral	edical Certificate:	Natural 5 Pending Accident Investigation S Suicide 6 Could not be	nonth, Day, Year) ace of Injury - At home, farmilding, etc. (Specify) be best of my knowledge, do basis of examination and/or	ury M 1 □ n, street, factory, office eath occured at the time investigation, in my opinic	? Yes 2 No date and place, a	28f. Location (Stre City or Town, and due to the cause at the time, date and	State) e(s) and manner as staplace, and due to the	ated. cause(s) and manner stated.
Hospi 24 hou Funer sted fill	Medical Certificate:	1 Natural 2	nonth, Day, Year) ace of Injury - At home, farmilding, etc. (Specify) be best of my knowledge, do basis of examination and/or	ury M 1 □ n, street, factory, office eath occured at the time investigation, in my opinic dge, death occurred at th 29c. License	? Yes 2 No , date and place, a on, death occurred a e time, date and place	28f. Location (Stre City or Town, and due to the cause at the time, date and uce, and due to the c	State) e(s) and manner as staplace, and due to the	ated. cause(s) and manner stated. stated.
To the Hospital or Attending Previous after death. To the Funeral Director: After the Completed filled in by the funeral	Medical Certificate:	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 1 Pending Investigation Investigation determined 6 Could not be determined 28e. Pl	ace of Injury - At home, farm illding, etc. (Specify) lee best of my knowledge, de basis of examination and/or er: To the best of my knowled	work on the street of the stre	? Yes 2 No , date and place, a on, death occurred a time, date and place and place and place number	28f. Location (Stre City or Town, and due to the cause at the time, date and uce, and due to the c	State) (s) and manner as staplace, and due to the ause(s) and manner as	ated. cause(s) and manner stated. stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State	State of Ma		artment of Heal		Hygiene	0 01000	
	Registrar Certificate of Death Reg. No U							0 34890	
Physic Med		Myrtle Jane	, casi) Westerr	1		2. Date o Month Octobe		Year 3. Time of Death 7:30 p M	
Exam	iner	4a. Facility Name (if not institution, 3701 International	,)4	4b. City, Town, or Locat Silver Spr		4c. County of Montgor		
Funera Directo		5. Social Security Number 579–34–1690	6. Sex 1 M 2 X F 80	(In yrs. last birthday) Yrs.	If Under 1 Year If Un Months Days Hou	nder 24 Hrs. 8. Date of Month	f Birth 20, 1930	Birthplace (State or Foreign Country) DC	
and show	ō	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Loc	eation			10d. Inside City Limits	
e Mary r 28a-f notifie	Direc	MD Mc	ntgomery		Silver Spring			1 ☐ Yes 2 ☐ No	
h with the rs 23a c	Funeral Director	3701 Internation	al Drive. Apt.	204	10f. Zip Code 2090	6	10g. Citizen of WI USA	hat Country?	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Fu	11. Marital Status 1 □ Never Married 2 □ Marr 3 1 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 X I If Yes, Give Year or Dates.	No If	Vas Decedent of Hispanio Yes, specify Cuban, Mex ☐ Yes 2 No Spe	kican, Puerto Rican, etc.)		- American Indian, , White, etc. Vhite	
Maryland 21215-0036 2 should be filed within 72 hours after Ith and Mental Hygiene. 27 is marked other than "natural", o	Completed	15. Deceder (Specify only higher Elementary/Seconday (0-12)	t's Education st grade completed) College (1-4 or 5-	(Give k	ent's Usual Occupation ind of work done during i NOT use retired)	most of working	16b. Kind of Bus		
d with hygien ther th	Be Co				ministrative A	Assistant	Army	/ Map	
yland Id be file Mental H Narked of	10 B	Arthur Sweeney					8. Mother's Name (First, Middle, Maiden Surname) Thelma Sullivan		
, Mar nd 2 shou ealth and n 27 is m er traum		19a. Informant's Name/Relationsh Daniel Michael Gr		19b. Mailin 8224	g Address (Street and Nu Reece Heights	mber or Rural Route Nur Drive, Severn	mber, City or Town, Sta , MD 21144	te, Zip Code)	
Baltimore, Department of Hea Important: If item any injury or other once.		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (S)			ition (Name of atory or other place) Ltan Crenatory	Oct. 24, 2010	20c. Location - C	city or Town, State	
Balti permit. Departr Importa any injt		21. Signature of Funeral Service Li	censee	77. 50	Name and Address of Fancis J. Colf O University I	ins Funeral Ho	me Inc. er Spring.MD	20901	
		23a. Part 1. Exter the disease, or shock, or leart failure. List of	complications that caused the cause of the cause on each line.					Approximate Interval Between	
Pnysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	_ a	erotic Heart	Disease			Onset and Death	
Examiner		Sequentially list conditions,	Atrial Fil	brillation					
and ransit	amin	Sequentially list conditions, if any leadin, from leadin, from leadin, from leading cause. Enter Underlying Cause (Disease or ilinjury that initiated events	. Hypertensi						
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ertificate ding physe as the		IF FEMALE:							
DIVISION OF VITAL RECORDS, F.O. BOX 08/10 the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ♣ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at t 9 Unknown	☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)		23d. Date Month	· ·	
es that the signed by	ρ	Part II. Other significant condition	s contributing to death but	not resulting in the un	derlying cause given in P		obacco use contribute to the cause of death?		
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VICAI iysician: is certific director,	To Be	examiner? 1 ☐ Yes 2 😿 No	Hospital:	t 2 ER/Outpatient	Othor:	Death (Check only one) Nursing Home 5 Re	esidence 6 Other (Pageifel	
Attending Phrt death. ctor: After th		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day,	28b. Time of	28c. Injury at work?	28d. Describ	e how injury occurred	<i>эреспуу</i>	
or Attence after deatl Director: in by the	Certificate:	2 Accident Investigs 3 Suicide 6 Could n 4 Homicide determin	ot be	- At home, farm, stree (Specify)	M 1 ☐ Yes 2	28f. Location	n (Street and Number of	or Rural Route Number,	
Hospital Hospital Hospital Funeral I ted filled	Medical	(Uneck 2 L Medical Ex	Physician: To the best of maniner: On the basis of exa	mination and/or investic	ation, in my opinion, death	occurred at the time, dat	e and place, and due to	the cause(s) and manner stated	
To the within 2 To the comple	ğ	29b. Signature and title of certifier	Turse Practioner: To the be	est of my knowledge, de	ath occurred at the time, of 29c. License number	date and place, and due to er	the cause(s) and manne 29d. Date signed (A	er as stated. #onth, Day, Year)	
10		30. Name and address of person with Marsha A. Seidelma		eli		36816	Octobe	r 21, 2010	
					· <u>-</u> · · · · · · · · · · · · · · · · · · ·	ng, MD 20901			
Sta Registr	te ar	31. Date filed (Month, Day, Year) OCT 22 2(Registrar's	Signature Sau	W				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State AMEND#41perMD, 11/1/10, BW, Moco Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JR Medical 4a. Facility Name (if not institution, give street and number) Woods Examiner Silver Spring 4c. County of Death ONI GOME! 6. Sex 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 1 🔀 M 2 🗆 F Months (Month, Day, JAN • 3 Director CZECHOSLOVAKIA Yrs 086-12-3874 90 920 Usual Residence of Deceden or 28a-f show notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director D.C. NONE 1 Yes 2 No WASHINGTON 9 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 3700 NORTH CAPITOL ST. N.W. 20011 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates. WWII 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", 3 Widowed 4 Divorced Completed Specify: WHITE the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event in 12 U.S. ARMY DEFENSE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ JOHN WASIL SR. ANNA STRACHAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DONALD WILKIE/BROTHER-IN-LAW BOUEBONNETT RD., LANGHORNE, PA. 19047 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON NAT'L. CEM.11-22-2010 ARLINGTON, VA. 21. Signature of Funeral Service Licenses CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. CLEVELAND AVE., RIVERDALE, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ THEROSCLE ROTIC disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 ☐ Yes Z ☐ 9 ☐ Unknown signed by t Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à TENOSIS, HTN, CHOL Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has within 24 hours after death.

To the Funeral Director. After this certificate I completed filled in by the funeral director, pag. performed' 2 1 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No |은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manney of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending iniury ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of my moveledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 0057630 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

MEORGIA

31. Date filed (Month, Day, Year,

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. Registrar's Signature

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ames R. Wise	, Jr.	State of Maryland / Department of Health and Mental F	lygiene	2010	34892		
		Registrar Certificate of Death		Reg. No.			
Physici Medical Exam		1. Decedent's Name (First, Middle,Last)	Date of Dea Month	Day Year	3. Time of Death 0045 hrs		
Wedical Exam	mei	JAMES ROSS WISE, JR. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deat	October 1	16, 2010 4c. County of Dea			
		2411 Washington Blvd Baltimore	m	Baltimor			
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr	rs 8 Date of Bi	irth(MM/DD/YYYY) 9. B			
Director		Months Days Hours Miles	n	Fore	ign		
		15.	10/11,	/1951	ountry) MD		
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits		
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MD 21215-0036 d 2 should be filed within 7 tht and Mental Hygiene. n 27 is marked other that aumagic event, the Medics	유	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or					
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Baltimore, permit. Pages 1 as Department of He Important: If ite injury or other tr				Funeral Hom			
	246 N. Washington St, Rockville, MD 2						
Physician Medical		failure. List only one cause on each line.	or respiratory arr	est, shock, of fleat	Approximate Interval Between Onset and Death		
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		Sequentially list conditions, b.					
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C	ami	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):					
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Vital Rec ysician: The his certificate director, page	å	25. Was case referred to medical examiner? [Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other4 Nursing 1 DOA OTHER4 NURSING 1 DOA OTHER4 NURSING 1 DOA OTHER4 NURSING 1 DOA OTHER4 NURSING 1 DOA OTHER4 NURSING 1 DOA OTHER4 NURSING 1 DOA OTHER4 NURSING 1 DOA OTHER4 NURSING 1 DOA OTHER4 NURSING 1 DOA OTHER					
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n of \ nding Ph; h. After tl	<u></u>	27. Manner of Death 28a. Date of Injury Oct 16, 2010 28b. Time of Injury 28c. Injury at Work? 28c. Injury at Work? 1 Natural 5 Pending 28c. Injury at Work? 1 Yes 2 ✓ No	House fire	now injury occurred			
Sio	cat	2 V Accident Investigation 28e Place of Injury - At home farm street factory office huilding etc.	28f Location /	Street and Number or Ri	ral Poute Number City		
Division pital or Attent ours after death teral Director.	ertification:	Suicide Could not be	or Town, S				
Hospi 4 hou Funer ely fil	ပ	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and (check only)					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.					
2	₹	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	nth, Day, Year)		
		(and Hell and O.C.M.E.		October 16, 201	0		
	ŀ	30. Name and address of person who completed cause of death (Item 23a)					
		Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2120)1				
S	ate	31. Date filed (Month, Day, Year) 37. Registrar's Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Ian Matthew Williford State of Maryland / Department of Health and Mental Hygiene 2010 34893 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Medical Examiner Ian Matthew Williford 1900 hrs October 19, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 13701 Flint Rock Road Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** 216-23-1623 Months Davs Hours Director 1 X M 2 F 22 Dec.24,1987 Mary land Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits s 23a or 28a-f show s notified at once, Marvland Rockville Montgomery 1 Yes 2 X No permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13701 Flint Rock Road 20853 United States Funeral 11 Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Ves 3 Widowed 1 Yes 2 X No specify. White 4 Divorced If Yes, Give Year Specify: ģ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 1 - 4Student College 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Theodore W. Williford Mary Linda Kadziel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theodore W. Williford -father 13701 Flint Rock Road Rockville, Maryland 20853 20a. Method of Disposition
1 Burial 2 X Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place! Metropolitan Crematory 10/20/2010 Alexandria, Virginia 4 Donation 5 Other Specify 22 Name and Address of Facility Donald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, 21. Signature of Funeral Service Licenses Bar Co Maryland20705 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical a. Contact Shotgun Wound of Head Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. sician/Medical UNPENDED AMENDED red by the attending physician detached for use as the burial -Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Phy P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed b ģ 1 Yes 2 No 3 Probably 4 Unknown Completed Records, has been si 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed page this certificate ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) of Vital Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other Scene 1 V Yes 2 No After 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Oct 19, 2010 Subject shot self Natural 1855 hrs Director: d in by the f Pending 1 Yes 2 V No e Funeral Director 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 🗸 Suicide Could not be or Town, State) 13701 Flint Rock Road, Rockville, MD determined (Specify) Single Family Home Homicide 29a. Certifier 1 To the Hosp within 24 ho To the Func Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Ga one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 20, 2010 30. Name and address of person who completed seuse of death (Item 23a)

State Registrar

Russell Alexander MD

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October John Randolph Waddle, Sr. 2°010 2:30 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Laurel Regional Hospita rince aure George's 5. Social Security Number 7. Age (In yrs. last birthday) 93 Yrs. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral 1 👿 M 2 🗆 F Days Hours 212-14-5710 Feb. 184,1917 Virginia Director Usual Residence of Decedent 28a-f shov 10h County 27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Hyattsville 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3309 Powder Mill Road 20783 United States 12. Was Decedent Ever in U.S. Armed Forces2.

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hydiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Exami 1 Tes 2 No Specify: White 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sheet Metal Worker construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ John Waddle Sue Holmes 19a. Informant's Name/Relationship (Type, Print) ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Code).
Powder Mill Road Hyattsville, Maryland 20783 John R. Waddle, Jr. -son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) George Washington Cem: 10/22/2010 Adelphi, Maryland Donald V. Borgwardt Fuenral Home, 4400 Powder Mill Road Beltsville, 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month 1 Yes 2 L 9 Unknown ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 NO မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death . Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident ☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check

Box (P.O. Records, within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, **Division of Vital** To the within 2

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Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 10 D70093 7300 Van Dusen Rd Laurel, MD 20707 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month) Registrar DHMH 17 Rev 7/2009 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34895 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 2010^{real} 9:05 Edward J. Wilson РМ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Crofton Care & Rehabilitation Center Crofton Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🖾 M 2 🗆 F Days Hours Min. Months (Month, Pay, Year) an. 14, 1916 **Director** 345-36-6819 94 Ohio Usual Residence of Deceden or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at Director 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Crofton 1 ☐ Yes 2 🖾 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1519 Elwyn Ave. 21114 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Wildowed 4 Divorced Specify: White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) 5 Federal Government Veterinarian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Porter Wilson Ellen Mitchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret A. Wilson / Daughter 8706 Nature's Trail #103, Odenton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) of the Fields 10/21/2010 | Millersville, MD Lady 21. Signature of Aneral Service Livensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying as a consequence of Examin attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal deat
Pregnant at time of death
Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 1 Tes 24a. Was an 24b. Were autopsy findings available s certificate has the lirector, page 2 s autopsy prior to completion of cause of 1 Yes 2 No Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 No ☐ Accident completed filled in by the Investigation Could not be 24 hours after deat Funeral Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within .
To the F only one) 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certi 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

Bowie,

MD

20715

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14300 Gallant Fox Lane

Arora,

OCT 19

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of Maryl		epartment of F Certificate of L		and Me		211	10	34896
Physicia	an/	1. Decedent's Name (First, Middle, Last) ALVIN R. WITC						2. Date of Dea		\/	3. Time of Death
Medi	cal							CTOBER	17^{Day} , 20	010 Year	12:14 A M
Examir	ner	4a. Facility Name (if not institution, give s Somerford Place	reet and number)		4b. City, Town, or	Location of				ty of Death e Aru	ndo1
Funeral		5. Social Security Number 6. Sex	7. Age (In y	rs. last birthd	ay) If Under 1 Year	If Under 2	24 Hrs. 8	B. Date of Birth	1	9. Birth	place (State or Foreign
Director		283-22-1241 1Usual Residence of Decedent	M 2 □ F 84	Yr	s. Months Days	Hours	Min. J	une 18	,1926	Ohic	itry)
and show	ē	10a. State 10b. County	10c.	City, Town o	r Location					1	10d. Inside City Limits
Mary 28a-f otifie	irec	Maryland Anne Arun	del	Da	vidsonville	9					1 ☐ Yes 2 🔀 No
ith the 23a or st be r	ra D	10e. Street and Number 716 Appomattox Rd.			10f. Zip Code 21(135			10g. Citizen of	What Cour	ntry?
Nore, Maryland 21215-U036 ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. It flem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Funeral Director		Was Decedent Ever in Agned Forces?	U.S.	13. Was Decedent of Hi	spanic Origi	in? (Specify	y Yes or No-		ce - Americ	
J36 after of al", or	d by	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 Ves 2 No If Yes, Give Year or Dates. W.W	. II	1 ☐ Yes 2 🛣 No		Puerto Ric	an, etc.)	Specifi	ack, White, o	
5-06 hours hatur dical B	Completed	15. Decedent's Edu (Specify only highest grad	cation	16a. De	ecedent's Usual Occup	ation		- 1	16b. Kind of E		nite
hin 72 ne. than "	mo	Elementary/Seconday (0-12)	College (1-4 or 5+) life.		,	kind of work done during most of working OO NOT use retired)					
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hyglene. 27 is marked other than "natural", o traumatic event, the Medical Exam	Be C	17. Father's Name (First, Middle, Last)	4 years	Nav	al Engineer I		"a Nome /F		Dep't. Maiden Surnam		<u>efense</u>
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lary		19a. Informant's Name/Relationship (Type	e, Print)	19b. N	lailing Address (Street a					State, Zip (
e, R and 2: Health em 27 ther tr		Alison F. Rolen/ D 20a. Method of Disposition			37 Solomons	s Isla	ınd Rd	l. Harw	ood, M	ary1a	nd 20776
IMOr Page 1 annent of F		1 ☐ Burial 2 🛱 Cremation 3 ☐ B	emoval from State	cemetery,	sposition (Name of crematory or other place	1	Date	·	20c. Location	•	
₽ ⊒ # # #		4 ☐ Donation 5 ☐ Other (Specify) 21. Sign		Kalas	Crematory 22. Name and Addres	s of Facility	10/18	/10	Edgewa	iter,	Maryland
Deparrii Deparrii Impor		Munde			22. Name and Address 2973 Solor	nons I	Island	Road,	Edgew	unera ater,	Home Md. 21037
		23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one	cations that caused the d	eath. Do not							Approximate
Pnysician/ Medical		Immediate Cause (Final disease or condition resulting in death)		eime	ris Di	seas	_			18	Onset and Death
Examiner			Due to (or as a cons	equence of):							
p ii	Examiner	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	equence of):							
rou cate be executed physician and the burial-transit	Exan	Cause (Disease or iinjury that initiated events c. resulting in death) Last	Due to (or as a cons	equence of):							
ou ate be ex hysiciar he buris	edical										
ertificate ertificate ding phy se as th		IF FEMALE:									
box of death cer	cian/	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pred 1 Live Birth 2 F	etal death		/				ate of delive	ery Day Year
ords, F.O. BOX 080, requires that the death certific been signed by the attending should be detached for use as	Physician/M	1							,,,,,,	Day real	
s that i	by P	Part II. Other significant conditions cont		resulting in th	e underlying cause give	en in Part I.		23e. Did tob	acco use cont	ribute to th	e cause of death?
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e law requires has been sig ge 2 should b	Completed							24a. Was an autops	y	Were autop prior to con death?	psy findings available inpletion of cause of
ding Physician: The law h. After this certificate has funeral director, page 2 !		25. Was case referred to medical			ge Dia	no of Dooth	(Oh = = !- = =	1 Yes 2		1 Yes	2 🗌 No
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al or A safter I Direct of in by		4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	nome, tarm, cify)	street, factory, office		28f.	Location (Str. City or Town,		ar or Rural I	Route Number,
DIVISION OF VITAL INCOLUSE, F.O. BOX 08.1 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Medical	Check 2 - Medical Examine	an: To the best of my kno On the basis of examina	tion ang/or inv	estigation. In my opinior	i death occu	urred at the	time date and	place and due	e to the call	eo/e) and mannor stated
the Fithin 2 the Fithin 2 the Fithin 2 the Fithin 2 the Fithin 2 the Fithin 2 the Fithin 2 the Fithin 2 the Fithin 3 the F		only one) 3 Certifying Nurse I	Practioner: To the best of	my knowledg	e, death occurred at the	time, date a	nd place, ar	nd due to the o	ause(s) and ma	anner as sta	ited.
or wit		James Verso	who		29c. License		19	29	d. Date signed	i (Month, D	ay, Year)
1	ļ	30. Name and address of person who con	pleted cause of death (It		, Print)	-5 11	1		1 1	1	
#15+1		31. Date filed (Month, Day, Year)	32. Registrar's Sign	1460	Ritchia	14 4	ghWn	-7	Arnola	(mc	21012
Stat Registra	_	OCT 1920	10 Seneur	. A.	bake						
				/	7						

Records, P.O. Box 68760, Vital 0

Certification: To Hospital or Attending To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: A completely filled in by the fu 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature av 29c. License number 29d. Date signed (Month, Day, Year) CA 201 Hall Highway-Crisfield, MD 21817 On Emerolnic Penariment State Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 2010 7:58 A.M Joseph Weathers Medical 4a. Facility Name (if not Institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Ctr. Cheverly Prince George's Funeral Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 1 Hours 84 May 1926 Director 250-34-3610 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits MD District Heights Prince George's 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2015 Weber Drive 20747 U.S. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 7-43-7-46 Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, African-American "natural", or Š 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: 3 X Widowed 4 Divorced Completed other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Accountant/Pastor Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Phoebe Weathers Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kamala Weathers-Daughter 2015 Weber Drive, Dist. Heights, MD 20747 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 10-30-10 Suitland, MD Lincoln Cemetery 4 Donation 5. Other (Specify) Signature July 22. Name and Address of Facility

Bonnette & Assoc. Funeral Home 2504 n28th St. NE ral Service License Sa. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or a Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Josh Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innerial director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last as a consequence of) attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 4 Pregnant a Pregnant at time of death Other (specify) Month Day Year 2 No Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Sulcide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar 29b. Signature and title

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) d Wil

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106 IRVING

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Ma	arylan				nd Mer	ntal Hyg	gienę.		34899	
		-	Registrar 1. Decedent's Name (First, Middle, Last) Certificate of						ate of Death 2. Date of Deat			Reg. No.		
P	hysicia Medic		Marie Young						00	Month ctober		2010 Year	3. Time of Death 10:09 A M	
*	Examin	er	4a. Facility Name (if not institution, g		•		4b. City, Town, o					ounty of Deat		
	uneral		Future Care Pin 5. Social Security Number 6	S. Sex 7. Age		ome ast birthday)	If Under 1 Year	Clint		Date of Birth			thplace (State or Foreign	
	rector		224-24-3702	1 □ M 2 🖾 F	88		Months Days	Hours		Month, Day	Year) 1922	Cor	untry)	
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with t	23a ust be	Funeral	9106 Pineview I	ane				0735			_		States	
Jeath	items ier mi	Fun	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S	. 13. V	Vas Decedent of H Yes, specify Cuba		n? (Specify	Yes or No-		. Race - Ame	rican Indian,	
36 affer c	l", or kamin	δ	1 Never Married 2 Marrie	1 Yes 2 XI If Yes, Give	No		☐ Yes 2 No		rueito nicai	11, 610.)	So	Black, White ecify: B1		
21215-0036 within 72 hours after death with the Maryland giene.	atura cal E	Completed	3 X Widowed 4 Divorced 15. Decedent	Year or Dates.	- 7	16a Decec	ent's Usual Occup	ation						
215 n 72 t	an "n Medi	ldm	(Specify only highest Elementary/Seconday (0-12)		.,	(Give I	ind of work done of NOT use retired)	during most o	of working	1	16D. Kind	of Business	industry	
withii yeiene	t, the		12th	College (1-4 of 3-	'	N	lurse's A	ide				Priva	ate	
land be filed ental Hyg	ed oth even	To Be	17. Father's Name (First, Middle, Las					18. Mother's	's Name (Fir			•		
Maryla should b	is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship	James Sr.		T				ula M		-		
	~ -		Floyd W. James			1	g Address (Street Crafton						0735	
Tanc 1 and	item 27 other tra		20a. Method of Disposition		20b. Pl	ace of Dispo	sition (Name of		ctobe			tion - City or		
Page	ant: If ury or		1 ☐ Burial 2 🔀 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				atory or other place Crematory	7 20	ctobei 010	r 23,	C1	linton	, Maryland	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene.	Important: If item 2: any injury or other t once.		21. Sunature of Funeral Service Lic	towar.	NE	22	Name and Addre	ss of Facility	Stewa ad NE	rt Fu Wash	neral	Home	Inc. 20019	
			23a. Part 1. Enter the disease, or co shock, or heart failure. List onl	omplications that caused y one cause on each line	the death	. Do not ente	r the mode of dyin	g, such as ca	ardiac or res	piratory arre	est,		Approximate Interval Between	
	ician/		Immediate Cause (Final disease or condition	Arteri	osc1	eotic	Cardiova	scular	Dise	ase _		- 4	Onset and Death Years	
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	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	conseque	ence of):						_	·-	
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ate be	hysici the bu	dical	•	d										
687	ding p	Physician/Me	IF FEMALE:	23c. If yes, outcome of	of pregnan	ncv								
Box	atten I for u	iciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🌁 No	1 Live Birth 2 4 Pregnant at	2 🔲 Fetal	death 3 [Ectopic pregnand Other (specify)	у			230	d. Date of del Month	Day Year	
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s that the	gned I	ρ	Part II. Other significant conditions	contributing to death bu	it not resu	ılting in the uı	nderlying cause giv	en in Part I.					the cause of death?	
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ř ř	ficate or, pag		25. Was case referred to medical					45		perform 1 Yes			2 🗆 No	
VITa /sicia	s certi	To Be	examiner? 1 Yes 2 XNo	Hospital:	nt 2 🗆 E	ER/Outpatien	Othe	er:				Other (Speci		
O Ph	her thi		27. Manner of Death	28a. Date of injury (Month, Day,	/ 2	28b. Time of injury	28c. Injury	/ at		Describe ho			пу)	
ION tendir leath.	or: Af	itica	1 X Natural 5 Pending 2 Accident Investigat 3 Suicide 6 Could no	tion		,		Yes 2 No	lo					
DIVISION tal or Attendir s after death.	Direct in by	Certificate:	4 Homicide determine		y - At hon <i>(Specify)</i>	ne, farm, stre	et, factory, office			ocation (St. City or Town		ımber or Rur	al Route Number,	
Spital	neral d filled	ical	29a. Certifier 1 X Certifying P	hysician: To the best of m	ny knowle	dge, death o	ocured at the time	, date and pla	ace, and due	to the caus	se(s) and m	nanner as sta	ited.	
he Ho	he Fu	Medical	(Check 2 Medical Exaconly one) 3 Certifying N	miner: On the basis of exa urse Practioner: To the b	amination est of my	and/or investi knowledge, d	gation, in my opinic eath occurred at the	on, death occu e time, date ar	urred at the ti nd place, and	ime, date and d due to the	d place, and cause(s) an	d due to the o	cause(s) and manner stated. stated.	
To t	10 t		29b. Signature and title of certifier				29c. License	number				igned (Month		
			MAIT		71	1	D185	545		C	ctobe	er 21,	2010	
23			30. Name and address of person when Philip Wisotsky	, M.D., F.A	.C.P.	1207		ne Cent	tre, 1	∮207 W	Valdo	rf, Md	. 20602	
R	Stat egistra	_	31. Date filed (Month, Day, Year) 007 2 5 2010	32. Registrar	's Signatu	lire /				_				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34900 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month David Eugene Baer Nov 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Longview Nursing Home Manchester Carroll 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 € M 2 □ F Dec. 21,1934 Months Hours Min. **Director** 75 Maryland 20-30-8806 Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Direct Maryland Carroll Hampstead 1 Yes 2 No 5 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be 23× 4723 Maple Grove Rd. 21074 U.S.A. or items within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 2 1 Never Married 2XXMarried Yes 2 ⋈ No Maryland 21215-0036 "natural", 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry e 1 and 2 should be filed within 72 r t of Health and Mental Hygiene. If item 27 is marked other than "n or other traumatic event, the Medi (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Gray & Son 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret Pauline Baer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl it of Health a trem 27 is David J. Baer - son B608 Oakleigh Rd. Parkville, MD. 21234 Baltimore, 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 💢 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Lutheran Cem. 8,2010 Manchester, Nov. Signature of Funeral Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. Gall 3296 Charmil Dr. Manchester, 21102 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Approximate Interval Between Immediate Cause (Final Onset and Death €hysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) burial-transit and that initiated events resulting in death) Last to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be as the l IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy detached for in the past 12 months? 5 Other (specify) Month Day Pregnant at time of death Year Yes 2 No 9 Unknown the Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be Division of Vital Records, 1 Yes 2 No 3 Probably 4 Vunknown been : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ပ 1 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 28d. Describe how injury occurred Natural work?
1 Yes 2 No 5 Pending injury Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 29a. Certifier Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signated and title of certifie 29d. Date signed (Month, Day, Year) d address of person who completed cause of death (Item 23a) (Type, Print) 30. Name an

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

Poole Rd.

W. estimmister

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month NOV. Day Physician/ 201°0 1:27 4 рм Margaret Luella Baublits Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Finksburg Bond's Forest Assisted Living If Under 1 Year If Under 24 Hrs. 8. Date of Birth De C. 18,1915 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. Hours 1 - M 2X- F Wirginia 213-16-0811 94 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho Director 1 Yes 2 No Maryland Hampstead Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21074 Funeral U.S.A. 3035 Shamer Lane Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian, 11. Marital Status Black, White, etc. Armed Force 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ¥☐ No Specify: If Yes, Give Specify: White Completed 3 XWidowed 4 Divorced Year or Dates and Mental Hygiene.
is marked other than "naturaumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Nental Hygien Important: If item 27 is marked other than my injuy or other traumatic. Sewing Factory Seamstress Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Tandy Dix Mamie Horne 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Phyllis Seipp - daughter 3035 Shamer Lane, Hampstead, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) NOV 20a. Method of Disposition 20c. Location - City or Town, State 7,2010 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hampstead, MD. Abraham's Ch. Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A 3296 Charmil 21102 Dr. Manchester, MD. 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequent Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury the burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregr 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mg Month Pregnant at time of death 5 Other (specify) 2 No been signed by the s should be detached t Yes P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 1. Yes 2 No Yes 2 L director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence Hospital: 1 🗌 Yes Z No 1 Inpatient 2 ER/Outpatient 3 DOA s after death.

Director: After this of in by the funeral dire 욘 Other Spe 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours after e Funeral Dire City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F 3 29b. Signature and title of certifier erson who completed cause of death (Item 23a) (Type, Print) Name and address 555 South Cate Street 1 NOTHIUSTON IMDOUST

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dav Year terling 50 Y : 05 A M 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Medical NIA Maryland Cerite Bultmore University 9 5. Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 8. Date of Birth (Month, Day Hours Min Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County should be filed within 72 hours after death with the Maryland and Mental Hygiene. ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director timore 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S 14. Race - American Indian ō Armed Forces Black, White, etc. 2 10 1 Never Married 2 Married Completed by 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify "natural". 3 - Widowed 4 - Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname မ 19a. Informant's Name/Relationship (Type, Print) City or Town, State 19b. Mailing Address (Street and Number or Rural Ro permit. Page 1 and 2 shr Department of Health an Important: If item 27 is any injury or other trau rnestine Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Location - City or Town, State 1 ☐ Burial 2 ☐ Cemation 3 ☐ Removal from State 70 4 Donation 5 Other (Specify) 21. Signat Funeral Service Lio 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cerebraranu disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 the IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death ed by the detached 9 Unknown P.O. signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è Division of Vital Records, Completed 2 ☐ No 3 ☐ Probably 4 X Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform this certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical director, æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No ျှ 1 Ninpatient 2 ER/Outpatient 3 DOA After thi funeral 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending death. Accident 1 Tes 2 \square No Investigation within 24 hours after death

To the Funeral Director: /
completed filled in by the f 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 24405 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21201

State Registrar Baltimore

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32. Registrar's Si

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3190 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 3 Physician/ Month 8:40PM 2010 Benjamin F. Blume Jr. JOV ember Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Hospital of Baltimore 8. Date of Birth (Month, Day, Year) 9–15–1960) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F 50 Months Hours Min. Director 218-76-8415 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Windsor Mill 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21244 USA 3223 Greenmeade Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces þ 1 Never Married Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: Specify: African-American 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Known as (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Machinist Crown Cork and Seal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willer Mae Fields Benjamin F. Blume Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edith S. Blume/Wife 3223 Greenmeade Road, Windsor Mill, MD 21244 Datient 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-13-2010 Woodlawn Cemetery Woodlawn, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. Of Balto. Co. 9200 Liberty Road, Randallstown, MD 23a. Part 1 There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shown, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Months Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown the Hospital or Attending Physician: The law requires that the death Month Pregnant at time of death signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 2 No 3 Probably 4 Unknown cate has been sit, page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn certificate 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 1 Nonpatient 2 ER/Outpatient 3 DOA ျ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 5 Pending 2 \square No 2 Accident Investigation 6 Could not be Suicide 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one and title of certifier ovember 3 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Antonia 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Bouthner Physician/ Robert JoseAL 00:41 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Carroll Hospital Center Westminster Carroll Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 □ F (Month, Day, Year) Hours Min. 219-40-9772 68 **Director** Yrs. MD Usual Residence of Decedent or 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Westminster MD Carroll 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 938 Westcliff Ct. 21158 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Automobile 12 Stockman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Edward Bouthner Anna Jenco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah Bouthner-wife Westcliff Ct., Westminster, MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Pleasant Valley Westminster, MD 4 ☐ Donation 5 ☐ Other (Specify) 11/8/10 22. Name and Address of Facility Fletcher Funeral Home 21. Signatura of Funeral Service Licensee homas U. 254 E. Main St. Westminster MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Lateral Sclcrosis Immediate Cause (Final Amyotrophic Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Examiner Due to (or as a consequence of): sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No 1 🗌 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 뎯 2 🔀 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? within 24 hours after death.

To the Funeral Director: Air completed filled in by the fu 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the hest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 11-4-2010 33561

State Registrar DHMH 17 Rev 7/2009 James

31. Date filed (Month, Day, Year) NOV 08 2010 Eldersburg MD. 21784

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's gignature

Fors

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #26 Per PHY G909 11/08/10 JH
State of Maryland / Department of Health and Mental Hygiene 2 1 1 For State Registrar 34905 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Gertrude C. Bavister Medical Nov. 2010 11:20PM 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 716 Walters Mill Road Harford Co. Forest Hill If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
May 30, 1917 **Funeral** Social Security Number . Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🖾 F Months Director 93 213-07-0407 Maryland Usual Residence of Decedent "natural", or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown mit yiny or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified as 10a. State 10b. County Director 10c. City. Town or Location 10d. Inside City Limits Maryland Baltimore **Dundalk** 1 🗆 Yes 2 🖁 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6916 Broening Road 21222 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Completed 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Years Beautician Cosmetology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) မ Edward T. Hartman Anna Pluemer 19a. Informant's Name/Relationship (Type, Print) Daug ter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Barbara A. Bradford P.O. Box 582 Forest Hill, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 [XOther (Specify) Encombrnen cemetery, crematory or other place) 11/8/2010 Bel Air Mem. Gdns. Bel Air, Maryland 21. Signature of Funeral Service Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Physician/ Immediate Cause (Final Onset and Death disease or condition resulting in death) desc 0/00 Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consequence on that the death certificate be executed signed by the attending physician and does detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months Pregnant at time of death Month 5 Other (specify) Day Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by the Hospital or Attending Physician: The law requires 1 Yes 2 10 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy After this certificate 2 N 2 No Yes 1 Yes 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital Daughter's 1 🗌 Yes 2 No Other: ပ 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 To ther (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Residence Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 \square Pending Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11-4-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1705 ma 2/224 32. Registrar's Signat State 8 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Bettv Bankard Ann 2010 November 8:20 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 35 E. Seminary Ave. Lutherville Baltimore 8. Date of Birth (Month, Day, Year Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 1 🗆 M 2 👿 F Days Hours Country)
Mary Land Yrs 215-90-3699 1962 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md.Baltimore Lutherville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 35 E. Seminary Ave. 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 K Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 1 ☐ Yes 2 🙀 No Specify: 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Electronics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Theodore Lokey Gladys Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Joseph F. Bankard,</u> Seminary Ave. Lutherville, Md. 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly <u>Hill Mem</u>. 11-6-10 Baltimore, Md. . Signature of Furferal Service License 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 <u>York Rd. Towson, Md.</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final tastalle disease or condition 6 Months resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2. No Month Day Year

Examiner the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760

attending physician and for use as the burial-transit Physician/Medical sate has been signed by the page 2 should be detached : After this certifical funeral director, p neral Director: A

certificate I

Completed by

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Certificate:

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23a or 28a-f show

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at

Physician

Medical

Examine

Baltimore, Maryland 21215-0036

9 🗌 Unknown		9 ∐ Unknown						
Part II. Other significant co	nditions cont	ributing to death but not res	sulting in the underlyi	ng cause given in Part	Edd. Did tobac	co use contribute to the cause of death?		
25. Was case referred to me	dical			00.51	24a. Was an autopsy performer	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No		
examiner?		26. Place of Death (Check only one)						
1 Yes 2 No	Ho	spital: 1 Inpatient 2	ER/Outpatient 3 [DOA Other: 4 🗆 Nu	ursing Home 5 Residence	e 6 Other (Specify)		
2 Accident In	ending vestigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 ☐ Yes 2 ☐	28d. Describe how i			
	ould not be etermined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, street, fac	28f. Location (Street City or Town, St	28f. Location (Street and Number or Rural Route Number, City or Town, State)			

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

harles

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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29d. Date signed (Month, Day, Year)

2010

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within 24 hours a

To the Funeral C

completed filled

Kobert 31. Date filed (Month, Day, Year) State Registrar

and address of per

on who compl

29a. Certifie

(Check only one Signature

32. Registrar's Signature

6569

ause of death (Item 23a) (Type, Print)

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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar 3490 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death County of Death seke 5. Social Security Number UNK 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Funeral 8. Date of Birth 1 M 2 LE Days Months Hours Min Director Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No 1100 10e. Street and Number ō 10f, Zip Code 10g. Citizen of What Country? traumatic event, the Medical Examiner must be Funeral 23a items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ò þ Maryland 21215-0036 1 ☐ Yes 2 ☐ Yo Specify: permit. Page 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exan If Yes, Give Year or Dates Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden, Surname) ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State /Date 1 Surial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) 21 Signal of Funeral Service Lin 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as capitac or respiratory shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Obstructive disease or condition resulting in death) Medical Due to (or as a consequence of) 8 hours Examiner pulmarais embolism Massive Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) law requires that the death certificate be executed for use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician a should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death 4 ☐ Pregnant a 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Cancer 2 No 3 Probably 4 Unknown 1 Yes has been 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a Was an page 2 autopsy e Hospital or Attending Physician: The I 24 hours after death. e Funeral Director: After this certificate h performed Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 1 No Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c, Injury at work?
1 Yes 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 🗆 No Accident Suicide Investigation completed filled in by the Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined Medical 🗜 🎖 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) within 2 To the I 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) ,2010

State Registrar

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31. Date filed (Month, Day, Year)

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Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kharal

November

upper chesaveake Dr Bel Ais IND 21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2018 North 2:16A M Physician/ 7 Norman Bernard Cline Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hampstead 4203 Wagon Wheel Dr. If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthdav) 5. Social Security Number **Funeral** (Month, Day, Y Months Days Year Country) 1**X** M 2 □ F 219-42-1818 66 Yrs MD Director Dec Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ehomany injuy or other traumatic event; the Medical Englishment. 10d. Inside City Limits 10b. County 10c. City, Town or Location Director Carroll Hampstead 1 Yes 2 X No MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 4203 Wagon Wheel Dr. 21074 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give 1 Never Married 2 Married ģ Yes 2X No Specify Specify: white 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Technology Elementary/Seconday (0-12) College (1-4 or 5+) Manager 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Claude Norman Cline Jr. Muriel Ann Mullin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carol Cline-wife 4203 Wagon Wheel Dr., Hampstead, MD 21074 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 20a. Method of Disposition cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State Evergreen Memorial 11-10-10 Finksburg, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Fletcher Funeral Home June al Service Licenses tional 21157 I St. Westminster, Md. 54 E.Main Part 1. Enter the disease, or complications that eached the death. Do not enter the mode of using, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death 23a Part 1 Enter the disease, or complications that Immediate Cause (Final Physician 0 disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year ned by the atter detached for u Month Day in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? 24 hours after death. Funeral Director; After this certificate has performed 1 Yes 26. Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 🗀 No 1 Yes Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Pragtioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatu

State Registrar

OHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

WASHMUSTER MODELES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Janet Chetram 03 2010 NOV /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Baltimore Reisterstown 12122 Statewood Road If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day,) 2–19–1961 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Year) Months 1 □ M 2 T F England 49 Director 220-80-1558 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State show an "natural", or items 23a or 28a-f show Medical Examiner reast be notified at 1 ☐ Yes 2 No Baltimore Reisterstown MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21136 USA 12122 Statewood Road Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married African-American altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than College (1-4or 5+) Elementary/Secondary (0-12) Bon Secours Hospital Mental Health Counselor 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be flik tment of Health and Mental H tant: If item 27 is marked oth Be Linda Malvo 27 is marked traumatic e James Coleman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 12122 Statewood Road, Reisterstown, MD 21136 Carl Chetran/Husband Department of Health Important: If item 27 any injury or other trong once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-10-2010 Pikesville, MD Druid Ridge Cemetery 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. of Funeral Service Licensee 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) day **Physician** Metastatic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-transit Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has lirector, page 2 s 2 No 1 ☐ Yes 1 ☐Yes ours after death. eral Director: After this certific filled in by the funeral director, i 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending 1 ☐Yes 2 ☐No investigation 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined. 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Division of Vital Records, P.O. Box 68760. e Funeral To the within 2

Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) #216 TOWSON, MD 21204 Bellona Addo

November 03, 2010

State Registrar

31. Date filed (Month, Day,

and manner stated.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lewis Earl Cole $20\overset{\text{Year}}{10}$ November 12:30P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 14 Cinnamon Drive Cecil Conowingo Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York **Funeral** 8. Date of Birth (Month, Day, Ye. Days 1 🛛 M 2 🗆 F Hours Vrs **Director** 093-20-0523 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoi any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Cecil Conowingo 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14 Cinnamon Drive 21918 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Ś 1 Never Married 2 Married Yes 2 😾 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 √ No Specify. Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Kane Transfer Elementary/Seconday (0-12) College (1-4 or 5+) Vice President Trucking Company 12 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Earl Cole Ellen McIntosh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Cinnamon Drive Conowingo, Maryland Mr. David L. Cole (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 € Other (Specify) Entombmen 11/8/2010 Middle River, MD Hill Mem. Gdns 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Colin Cane disease or condition Vean Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Dav Year Pregnant at time of death Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at within 24 hours after uccom.

To the Funeral Director: After t 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Could not be Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State)

State

DHMH 17 Rev 7/2009

Registrar

Medical

29a. Certifier

(Check

only one) 29b. Signature and title

31. Date filed (Month, Day, Year)

cause of death (Item 23a) (Type, Print)

9103

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Medical Examiner: On the basis or examination and on investigation, in this opinion, seath occarroo at the sine, which is the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Franklin Square Drive Ste. Haw &

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 2010 Louise Colson 11:30 AM Mary Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll 1850 Francis Scott Key Highway Keymar 8. Date of Birth
(Month, Day, Y
NOV • 24, **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Year) - 1<u>934</u> 1 □ M 2**X** F Days Hours Maryland Director Nov. 212-32-4755 75 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. ant: If item 27 Is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 Yes 2 XNo Carroll Keymar Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21757 1850 Francis Scott Key Highway Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 XMarried ☐ Yes 2 🛣 No Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Specify: 3 Divorced 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) own home homemaker 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Clayton Staub Ruth Virginia Reaver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th 1850 Francis Scott Key Hgwy. Keymar, MD 21757 William D. Colson/ husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sams Creek Cemetery 11/4/2010 nr. Dennings, MD 22. Name and Address of Facility Hartzler Funeral Home attarine Union Bridge, MD 21791 Broadway 23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each fine. eath. Do not enter the mode of dying, s Approximate Interval Between and Death Immediate Cause (Final Ph. sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events could be a control of the Physician/Medical Examiner Due to (or se a attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be a 24 hours after death. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death Unknown 9 Unknown Division of Vital Records, P.O. Part Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 2 🗌 No 1 Yes Yes Director; After this certification by the funeral director, I 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 1 🗆 Yes 2 🗷 No 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending injury 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide determined City or Town, State) within 24 hours a Medical 29a. Certifier 1/🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

Registrar

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completed cause of death (Item 23a) (Type,

26516

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month eler 018AM Medical a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Towson **Baltimore** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Months Days Hours Min Mary land Yrs **Director** 88 216-16-3740 Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Cockevsville 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1129 Greenway Road 21030 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Black & Decker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ C. Elmer Nau Mary Belle Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Annette Zubritsky / Niece 1129 Greenway Road Cockeysville, Maryland 21030 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 11/6/2010 Hilltop Serv. Corp. Towson, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Aspuration disease or condition Medical resulting in death) Due to (or s a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Due to for as a consequence of Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death been signed by the should be detached g 🗍 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has to autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Shother (Specify) Hospital: 2 X No trent 1 🗌 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? injury 1 ANatural 5 Pending 2 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) R125808 at, com 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
67-21 N. Charles St., St. 4105 Vellanere VA. ADAC 0

Registrar

State

31. Date filed (Month, Day, Year) NOV 0 8 2010

32. Registrar's

Signature

10-08361

Control Cont	Jnk Unk		State of Maryland / Department of Health and Certificate of Death		2010 34913	
## As Pacify Name (Front established passed and number)		n/	Registrar 1. Decedent's Name (First, Middle, Last) Jose Luis Astacio, JR.	2. Date of De	ath 3. Time of Death	
103-96-2790			4a. Facility Name (if not institution, give street and number) Route 113 South of Langmaid Road 4b. City, Town, or Lo Newark	cation of Death	4c. County of Death Worcester	
This size and number The size of the size			103-96-2790 1 M 2 F 3 Yrs. Months Days	Hours Min.	Foreign Country)	
POSCION EXAMINED TO SET AND THE FIRM ALE: The Find Alless or complete of the second	215-0036 be filed within 72 hours after death with the Maryland antal Hygiene. rked other than "natural", or items 23a or 28a-f showent, the Medical Examiner must be notified at once.	Be Completed by Funeral	10a. State NY Bronx 10c. City, Town or Location NY Bronx 10c. City, Town or Location B1 10e. Street and Number 10f. Zip Code 879 Macy Place 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No If Yes, specify Cuban, Married 2 Married 10 Yes 2 X No If Yes, Secondary (College (1-4 or 5+) O N/A 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) O N/A 17. Father's Name (First, Middle, Last) 18. Jose Astacio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Carmelo Dominguez, Jr. (Uncle) 879 Macy Place 20a. Method of Disposition (Name of cemet	10455 nic Origin? (Specify Yes or Notexican, Puerto Rican, etc.) specify:Dominican (Give kind of work done O NOT use retired) Mother's Name (First, Middle, Christina A nd Number or Rural Route Nu e, Bronx, NY 1 tery, Date	USA De 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry N/A Maiden Sumame) ida Domingues mber, City or Town, State, Zip Code) 0 455	
Physician Examiner The proposed programme and the programme and the progr	Baltimore, permit. Pages l at Department of He Important: I fite		1 X Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: 21. Signature of Funeral Service Consecution 3 111 Mou	Nov. 08 ery 2010 Facility Stalling Intain Road, Po	Bronx, New York ngs Funeral Home, P.A. asadena, MD 21122	
Note Part	Ale oir al Examiner		failure. List only one cause on each fine. Immediate Cause (Final dinease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated a. He ad and Neck Injuries Due to fir as a consequence of): Due to (or as a consequence of):	ch as cardiac or respiratory ar	Between Onset and	
1 Yes 2 No 3 Probably 4 Unknow 24a. Was an autopsy performed? 1 Yes 2 No 3 Probably 4 Unknow 24b. Were autopsy findings availage profit to completion of cause: death? 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only) one) 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Nov1. 2010 1644 hrs 28a. Date of Injury 1644 hrs 28b. Time of Injury 28c. Injury at Work? 1 Astural 3 Suicide 6 Could not be determined 28d. Location (Street and Number or Rural Route Number, Control of the Homicide examiner? 1 Yes 2 No 2	68760, certificate be execui nding physician and	<u>ह</u>	d. UNPENDED X AMENDED PER ME g910 12.6.10 TT IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Pregnant at time of death 5 Other (Specify)	Ectopic pregnancy		
A gray of the second of the se	of Vital Records, P.C ng Physician: The law requires that Mer this certificate has been signed I meral director, page 2 should be deta	To Be Completed by	25. Was case referred to medical examiner? 1	1 _ Ye 24a. Was autoj perfc 1 _ Yes Death (Check only one) ner4 _ Nursing Home 5 _ 2t Work? 2 _ No 28d. Describe Passenger ding, etc. 28f. Location (an 24b. Were autopsy findings available prior to completion of cause of death? 2 V No 1 Yes 2 No Residence 6 V Other: Scene how injury occurred auto auto collision Street and Number or Rural Route Number, City	
Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	8 - 8 5	-	29b. Signature and title of certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date a cone) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, de and manner stated. 29b. Signature and title of certifier 29c. License no	and place, and due to the cause eath occurred at the time, date umber	se(s) and manner as stated. and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)	
Registrar MUV 00 2010 Description of Section 1		ate	Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Ba 31. Date filed (Month, Day, Year) 32. Registrar's Signature	altimore, MD 21201		

Registrar

OCME

10-08358

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Jnk Unk	1- For State Registrar	tate of Maryla		ment of ficate of		d Mental I		20 eg. No.	10 3491
Physician/ Medical Examine	1. Decedent's Name (First, Mide		inguez				2. Date of Dea Month Novembe	ath	3. Time of Death 1649 hrs
	4a. Facility Name (if not instituti RT 113 South of Lan	on, give street and num		41	. City, Town, or I Newark	ocation of Dea		4c. County of Worceste	
Funeral Director	5. Social Security Number 065-62-9565	6. Sex 7	7. Age (In yrs. last		If Under 1 Year Months Days	If Under 24H Hours M	in.	rth(MM/DD/YYYY) L6/1957	 Birthplace (State or Foreign Country)D ominicar Republic
v any	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Locatio					10d. Inside City Limits
ith the Maryland 23a or 28a-f show notified at once. al Director	N Y 10e. Street and Number	Bronx			B 10f. Zip Code	ronx	1	10g. Citizen of Wha	1 X Yes 2 No
by MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sh traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 X M 3 Widowed 4 Di	12. Was Dece Armed For 1 Yes vorced If Yes, Give Year or Dates:	2 X No	If Yes	s, specify Cuban, res 2 No	Mexican, Puer	minican	o- 14. Race - White, Specify:	White
5-0036 ed within 72 hours tygiene. other than "natuu the Medical Exam Completed	15. Decedent's Education (Sp. Elementary/Secondary (0-12		172 1993	during mos	Usual Occupation of working life.	DO NOT use re	etired)	16b. Kind of Busin	ness/Industry ruction
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical To Be Comple	Wenceslao A	mancio Do	ominguez		1	8.Mother's Nam Idalia	ne (First, Middle, I	Maiden Surname) .nquez	
MD 21 nd 2 should salth and Me em 27 is ma raumatic ev	19a. Informant's Name/Relation Carmelo Doming 20a. Method of Disposition		(Son)	879 N	,	ce, Bro		York 104!	
Baltimore, permit. Pages I ar Department of Hee Important: If ite	1 X Burial 2 Cremation 4 Donation 5 Other 5	pecify:	n State cren	natory or othe Raymon	rplace) ds Cemet	No ery	v. 08 2010	Bronx,	New York
	21. Signature of Funeral Service 23a. Part I. Enter the disease, o	(read the death. Do	3		ntain R	oad, Pas	adena, MI	
Physician Lxaminer	failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line. a. Multiple Injui		, not onto the	mode of dying, c	337 43 34 443	or respiratory air		Between Onset and Death
uted d ansit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	consequence of);	.=					
50, te be executed ysician and burial - transit	UNPENDED IF FEMALE:	AMENDED	utcome of pregnan	04				23d. Date of de	alivary
Box 68760 e death certificate to the attending physical for use as the budysical Msician/Me	Z3b. Was decedent pregnant in to past 12 months? 1 Yes 2 No 9 Ur	he 1 Live bir	th nt at time of death	2 Feta	death 3 [Ectopic pregi	nancy	Month	Day Year
ires that the de signed by the detached f	Part II. Other significant condi	tions contributing to	death but not resul	lting in the und	derlying cause gi	ven in Part I.			te to the cause of death? Probably 4 Unknown
Division of Vital Records, P.O. Box 6876C To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physomopletely filled in by the funeral director, page 2 should be detached for use as the bedical Certification: To Be Completed by Physician/Me	25. Was case referred to medical	si I			26 Place	of Death (Chec	1 Yes	osy prio rmed? dea	ere autopsy findings available or to completion of cause of ath? Yes 2 No
F Vital Physician r this certi	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inp		/Outpatient	3 DOA	Other Nurs	ing Home 5	Residence 6	
Division of 's spital or Attending Phours after death. meral Director: After of filled in by the funeral Certification: T		ding 28a. Date of (Month, 1) Nov 1, 20	Pay Year)	b. Time of Inju 344 hrs	1 Ye	r at Work? es 2 ✔ No	Driver of a	how injury occurred minivan struck	oncoming car
Divisior Hospital or Attend 24 hours after death Funeral Director: stely filled in by the	3 Suicide 6 Could not be determined (Specify) Major Road / Highway 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) RT 113 South of Langmaid Rd, ,								7
To the Howithin 24 h To the Fun completely	one) 2 ✓ Medical Exa	hysician: To the best aminer:On the basis of and manner sta	examination and/o		n, in my opinion,	death occurred		and place, and due	to the cause(s)
	29b. Signature and title of certification	Teller ?	ede 3	030	29c. License O.C.M			29d. Date signed November 2,	(Month, Day, Year) 2010
	30. Name and address of person Victor Weedn MD JD	Assistant Med		•	nn Street, Ba	altimore, MI	21201		
State Registrar	576.0 1.3.7	8 2010 32. Reg	istrar's Signature	b. So	ukad				

3. Time of Death

1649 hrs

10d. Inside City Limits

1 XYes 2 No

Approximate Interval

Between Onset and

Death

Year

To the Hospital or Attending Physician: Division of Vital within 24 hours after death.

To the Funeral Director: completely filled in by the fi

28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) Route 113 South of Langmaid Road , Newark , MD determined (Specify) Major Road / Highway Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and Inanner stated 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. November 2, 2010 30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day NOV 32. Registrar's Signature ^Yເປົ້⁽²⁾່ວ 2010

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1:28 PM na October 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NIA Memoria ritimore If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday If Under 1 8 Date of Birth Funeral 1 M 2 - F Months Days Min. Director Usual Residence of Decedent or 28a-f show 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 Nes 2 No HMORL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Alamed 21239 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Porces? Black, White, etc 0 Completed by 1 Never Married 2 Married 1 Yes 2 ☐ No If Yes, Give Maryland 21215-0036 Blac 1 Yes 2 No 3 ☐ Widowed 4 ☐ Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT,use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18_Mother's Name (First, Middle ည 19a. Informant's Name/Relationship Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City Town, State, Zip Code Katherine permit. Page 1 and 2 Department of Healtl Important: If item 2 any injury or other 1 or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location City or Town, State Date gemetery, grematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Hmore awa 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ligenses Rollins Funeral 2170 3a. Part 1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ GI disease or condition UPPER UNKAOWN Medical resulting in death) Due to (or as a consequence of) Examiner Peritonitis Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed after death. ESRD Years that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE page 2 should be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death 2 No Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 1 🗌 Yes 2 🗆 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2-1 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attentum surviving within 24 hours after death.

To the Funeral Director; After the 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 🗌 Yes 2 | No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29h. Signature and title of certifier 8946 26,2010 AT 243 october 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Beltimor, ND Gonzalo Union Memorial 21218 Hospital 201 E. University

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ November 0528 AM Eckrich 2010 atherine Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Barriew Medical Center Baitmore Johns Hopkins 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Funeral Feb. 21, 1932 Days Months Hours Min. 1 M 2 TXF Mary land 78 218-28-7589 Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at. 10d, Inside City Limits 10a. State 10b. County 10c. City. Town or Location Director 1 Yes 2 X No Baltimore Edgemere Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 21219 2825 Lodge Farm Road Apt. 308 i and 2 should be filed within 72 hours after death f Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. ğ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 XWidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Funeral Service 12 Years Hostess Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ဂ္ Gertrude Catherine Schwarzkopf James Grover Wells 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. John Lawrence Olson, Jr. 1535 Franklinville Road Upper Falls, MD injury or other 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

✓ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/5/2010 Sykesville, MD Crestlawn Cemetery 4 Donation 5 Other (Specify) Signature of Funeral Service License Duda-Ruck Funeral Home of Dundalk, 21222 Dundalk, Maryland 7922 Wise Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Approximate** Interval Between Onset and Death Immediate Cause (Final Physician/ Respiratory Failure 8 hours disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner week Preumonia Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit mon ths ymphoma that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 Natural work' 5 Pending after death. Director: Aft 1 🗌 Yes 2 No Investigation ☐ Accident ☐ Suicide within 24 hours after death

To the Funeral Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 000 2010 RES November 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21224 Eastern Avenue Baitimore. Keiko Greinberg 4940

OHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year,

0 8 2010

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 5:00 A. M Bobby Fletcher November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Gilchrist Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day.)
April 2 6. Sex 1 M 2 D F 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Months Year) 948 South Carolina Director 218-44-5966 62 Yrs Usual Residence of Decedent 28a-f shov 10a. State 10b County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Baltimore must be notified N/A Maryland 1 Yes 2 No 10f. Zip Code 21217 ъ 10e. Street and Numbe 10g. Citizeng AWhat Country? Street APT.112 23a Funeral 301 McMechan 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) 12th grade College (1-4 or 5+) the Construction Worker Merritt Concrete Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Vernon Fletcher Ella Mae Rattley permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marks any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 901 Perry Avenue Dillon, South Carolina 29536 Ella Mae Rose/ Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Zion Cemetery 11-06-2010 | Lansdowne, MD 21. Signatu Funeral Servic Censee 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, MD 21215 23a, art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ UMPLICATION disease or condition resulting in death) LACS Medical Due to (or as a consequence of) **Examiner** Ima VNO Sequentially list conditions. Examine if any, leaving to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed ig physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Pregnant at time of death Day Year 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been signe should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performed? Yes 2 No After this certificate | funeral director, page 2 No 1 Tes 25. Was case referred to medica examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 1 Natural 28b. Time of Certificate: 28c. Injury at injury 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 Yes 2 No M ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signa

DHMH 17 Rev 7/2009

Registrar

are and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHAZURS

MOV 0 8 20

20

32. Registrar's Signature

Basses

6701

29c. License number

nanco

1J

29d. Date signed (Month, Day, Year)

November

TUNISUN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		,	1 - For State Registrar	State of Marylan		artment of l tificate of		Mental Hy	/giene Reg. No	2010	34919	
	Physicia		1. Decedent's Name (First, Middle, Las Glady S Fa	1.4				2. Date of D Month No ven	eath Da	ay Year	3. Time of Death	
Examiner 4a. Facility Name (if not institution, give street				street and number)		4b City, Town, o	or Location of Deat			County of Death	3:15° M	
	Funeral	H	Season's Hosk 5. Social Security Number 6/Se	If Under 24 Hrs		Birth 9. Birthplace (State or						
	Director		212-30-2101 Usual Residence of Decedent	□M2 V F 93	Yrs.	Months Days	Hours Min.	8 - S	ay, Yoar)		ntry) N.J	
	yland -f show ed at	ctor	10a. State 10b. County	10c. City	, Town or Loc						10d. Inside City Limits	
	the Mar or 28a e notifi	Dire	10e. Street and Number	100	1 tim	Orc 10f. Zip Code	_		10a. Ci	itizen of What Cou	1 Yes 2 No	
	th with ms 23a must b	Funeral Director	2912 Norfolk	Avenue	1 100		1215			USA		
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	l II	Vas Decedent of F f Yes, specify Cub Yes 2 No	lispanic Origin? (S ap-Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	-	14. Race - Ameri Black, White Specify: 72 /		
21215-0036	72 hour n "natu 1edical	Completed	15. Decedent's Ed (Specify only highest gra	ucation	(Give F	ent's Usual Occup	during most of wor	rking	16b. K	Kind of Business In	ndustry	
	within ygiene.		Elementary/Seconday (0-12)	College (1-4 or 5+)	iiie. Do	NOT use retifed)	/		Car	la Domi	ngos College	
Maryland	ld be filed Mental Hyg arked oth atic event	To Be	17. Father's Name (First, Middle, Last) Charles E1	ley	18. Mother's Name (First, Mid Edna B.					dle, Maiden Sumame)		
	and 2 should be fil Health and Mental tem 27 is marked ther traumatic ev		19a. Informant's Name/Relationship (Ty	oe, rint)	19b. Mailin	g Address (Street	and Number or Ru	ral Route Numb	1 /		Code) 1) 21215	
Baltimore,	Page 1 and nent of Hee ant: If item ury or othe		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State 199		sition (Name of nators or other place	ce)	Date		ocation - City or T		
altim	permit. Page Department of Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service License) K	195 22	Park Name and Addre	ss of Facility au	3-2010	130	altimon ne Funen	(Services	
ñ	permir Depar Impor any ir		Vaugher C.	Breine	8	728 Lil	perty Ro	1 Rand	a/13		11) 21133	
	Physician/	86 3	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on Immediate Cause (Final disease or condition	e cause on each line. Athero Scle				Disease			Approximate Interval Between Onset and Death	
	Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):							
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to or as a conseque	ence off:							
	cate be executed physician and s the burial-transit	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	Due to (or as a conseque	a consequence of):							
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8	certific nding use as		IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnan 1 ☐ Live Birth 2 ☐ Fetal	cy					23d. Date of deliv	rerv	
S. Box	law requires that the death as been signed by the atte s 2 should be detached for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of de		Ectopic pregnand Other (specify)				Month	Day Year	
s, P.(s tha	۵	Part II. Other significant conditions co	ntributing to death but not resu	lting in the ur	nderlying cause gi	ven in Part I.				he cause of death?	
örd	iw requi	Completed						24a. Was	an	24b. Were auto	psy findings available	
8	The atte page		05 Was and a said at					auto perfo	psy ormed2 2 No	death?	empletion of cause of	
Vita	nysiciar nis certif directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1	R/Outpatient	Oth	ace of Death (Checer: 4 Nursing H		dence 6	Other (Specific	tient hospice	
Division of Vital Records, P.O.	To the Hospital or Attending Physiciam: within 24 hours after death. To the Funeral Director. After this certific completed filled in by the funeral director,	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? 1				28d. Describe how injury occurred				
DIVIS	ital or Att urs after d ral Direct lled in by t		4 Homicide determined	building, etc. (Specify)						ocation (Street and Number or Rural Route Number, Sity or Town, State)		
	ne Hosp n 24 ho ne Fune pleted fi	Medical	(Check 2 ☐ Medical Examin	cian: To the best of my knowled er: On the basis of examination a Practioner: To the best of my I	and/or investig	gation, in my opinio	n, death occurred a	at the time date a	and place	and due to the ca	ucole) and manner stated	
	To the Community of the		29b. Signature and title of certifier NS Ruj cyfilmse			29c. License				e signed (Month,		
			30. Name and address of person who co	mpleted cause of death (Item 2	23a) (Type, Pr 2 <i>§</i> 3	int) S Smith	Av. S	5-203,	В	altimor	P, ND 21209	
	Stat Registra	-	31. Date filed (Month, Day, Year) NOV 0 8 2010	32. Registrar's Signatu	park	W						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Year Franklur Mary 9:31 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death GILCHRIST HOSPICE CENTER Baltimore County Towson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 😿 F Months Days Hours Min Mary I and Director 84 219-16-9835 June Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore County Essex 1 Yes 2X No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 407 Hopkins Landing Drive 21221 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Residence 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Janes Frances Golden Adelaide Mary Sloan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert A. Franklin (Husband) 407 Hopkins Landing Drive, Essex, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Dul Valley Mem Grdns | 11/10/2010|Timonium, Maryland 21. Signatur of Funer Serv L Company

Martin D. Lawson MITCHELL WIEDEFELD FUNERAL HOME, INC 6500 York Road, Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Due to () r as a consequence of): ration Medical Examiner promic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence or, physician and sthe burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Dav Year signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has }; page 2 s autopsy performed After this certificate funeral director, pag ☐ Yes 2 💢 No 2 No 1 \square Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation tor: the Funeral Directory filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of certifier 29c, License number V, Cans 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) F. N. Cha

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

NOV 08 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Year Terrell Geter 8:45 n November 2010 Medical Seasons Hospice@Northwest Hospital Center RANDALLSTOWN 4a. Facility Name (if not institution, give street and number) Examiner Baltinore 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Spate of Birth 5 1949 **Funeral** N. Birbalece VSTate ok Foreign 1 ₹ M 2 □ F Months Davs Hours Min. 214-56-7031 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland "natural", or items 23a or 28a-f sho oc. City, Town or Location Windsor Mill 10d. Inside City Limits Director Baltimore Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 21244 10g. Citizen of What Country? Funeral 3721 Washington Avenue permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?
1

Yes 2 □ No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify 3 Divorced 4 Divorced Year or Dates. event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Industries 12th grade Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joyce Marie Farrer Darrow Thomas Geter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3721 Washington Avenue Windsor Mill, MD 21244 Joyce M. Gardner/Mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City of Town, State 11/9790 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt.cerzejoggre@@metoegryace) injury or 21. Signature of Funeral Service Licer 22. Name and Address of Facility Chatman—Harris Funeral Home 5240 Reisterstown Rd Baltimore, MD 21215 any 23a. Part 1 Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ end-stage Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been signification categories, page 2 should be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed After this certificate funeral director, pag 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No ithin 24 hours after death.

the Funeral Director: Aformpleted filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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State Registrar

D0057 465

11/4/10

Baltimore, MD. 21209

MSKujapahreM.D

N.S 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

. Rajapakse, M.D

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TITEM 2015, perfff, G909, 11/10/2010, WS#12

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Green Physician/ october 1906 PM 2010 Medical 4b. City, Town, or Location of Death
Ballmore 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center N If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** Months Days Min. (Month, Day, Director Usual Residence of Decedent or 28a-f shov nit. Page 1 and 2 should be filed —ithin 72 hours—fter death with the Maryland outrinent of Health and Mental Hyciene.
Another if item 27 is marked other than "natura", or items 23a or 28a-f showing the filem 27 is marked other than "natura", or items be notified at injury or other traunatic event the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21201 Le Was Decedent Ever in U.S. Armed Forces? 1 2 Yes 2 If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status

1 Never Married 2 Married 14. Race - American Indian, Black, White, etc. Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 2 No Specify. Specify: 3 Widowed 4 Divorced Year or Dates. Navy 15. Decedent's Education 16a Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be Department of Health and Mer Important: If item 27 is marke any injury or other traumatic 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) Apt 201 2/17 MEZ 20a. Method of Disposition 20b. Place of Disposition (Name of Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 11/16/2010 4 ☐ Donation 5 ☐ Other (Specify) ores 21. Signature of Funeral Service Licens 22. Name and Address of Facility to MU 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial or respiratory shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Day Year 2 No 9 Unknown 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed . Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No 1 🗌 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Matural Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 2 🗌 No М 1 Yes within 24 hours after death

To the Funeral Director of completed filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practice on To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and marrier as stated 29b. Signature and title of certifier 29c. License number D0028684 Become 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Elwand S beginner und 4940 Euskin Avenui, Ballimore, MD, 21224 31. Date filed (Month, Day, Year) State NOV 0 8 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ Virginia Lee Gilleas November 4:32 P. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5806 Apt. D. Western Run Drive N/A Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 05–18, 1949 **Funeral** 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Hours 1 M 2 X F 61 Director 211-36-6676 Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No Marvland N/A **Baltimore** 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 21209 5806 Apt. D. Western Run Drive 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No Specify Specify Completed 3 Widowed 4 X Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nr any injury or other traumatic account." (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Horse Racing Industry Horse Trainer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Melvin Brown Violet Lobkowitz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melvin Brown - Father 1424 Bobolink Lane West Chester, PA 19382 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Binding Place)
Latayette Cemetery 20c. Location - City or Town, State 🔀 Burial 2 🗆 Cremation 3 🗆 Pernoval from State 4 Donation A □ ou 11-11-2010 West Chester, Pennsylvania 21. Sign 22. Name and Address of Facility Leonard J. Ruck Funeral Home, Inc. 5305 Harford Road Baltimore MD 21214 23a. Part 1. Er er the disease, r cor shock, o he rt failure. List only r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Crus (Final disease or condition Physician/ Medical resulting in darm) Due to (or as a consequence of) Examiner 05 Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause Disease or impury Due to (or as a consequence of) requires that the death certificate be executed sician and burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Pregnant at time of death signed by the a 2 No 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, cate has been sig page 2 should b Completed 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law autopsy 1 Yes 2 No To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to edica Be **Division of Vital** 26. Place of Death (Check only one) examiner? 2 No မ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) Medical 29a Certifier Letrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, 2010 completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) NOV 08 2010 32. Registrar's Signature State

OHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) John Anthony Guerrasio Physician/ November 4 20**°T**O 10:10a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOWard Columbia Somerford Place Assisted Living 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 1 □ M 2 □ F Days Hours 215-32-6967 75 Director MD Sept Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Ellicott City 1 Yes 2 No MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10401 Boca Raton Drive 21042 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Ves 2 No Korea
If Yes, Give
Year or Dates. Black. White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Specify: white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) NSA College (1-4 or 5+) analyst permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Genevieve Doering Michael Anthony Guerrasio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin Code) 10401 Boca Raton Dr., Ellicott City, MD 21042 Gail Guerrasio (spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Sykesville, MD 11-9-10 Lake View Memorial 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Pary Haight Serbert Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final Physician/ Alzheimer's Disease disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence on attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: Live Birth 2 Fetal death If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Month Year signed by the aid be detached for 9 Unknown g Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown been si should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy performed?

1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence & dispersion living 1 Yes 2 🗆 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral is 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 2 Accider 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier 1 🙀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 07, 2010 M.D. D56531 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harry Li M.D., 8600 Snowden River Pkwy, Columbia, MD 21045 31. Date filed-(Month, Day, Year) 32. Registrar's Signature State NOV 08 2010

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 5, 2010 Physician/ Constant J. Georges Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Baltimore 4b. City, Town, or Location of Death **Examiner** Towson Gilchrist 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 7. Age (In vrs. last birthday) Funeral Min June 27, Year) 1917 1 X M 2 - F 93 Cyprus 226-34-2987 Director Usual Residence of Decedent 28a-f show 10b. County 10a, State 10c. City, Town or Location Examiner must be notified at Director MD Baltimore Towson ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 615 Chestnut Avenue #343 21204 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. id Mental Hygiene. marked other than "natural", or þ 1 Never Married 2 Married 1 X Yes 2 No If Yes, Give 55-56 Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Completed 3 Widowed 4 Divorced Year or Dates. the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Dentist Dentistry or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Georgiades Evrodiki **Eflombiou** Jacavos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health at Important: If item 27 is any injury or other tran 2525 Paper Mill Rd., Phoenix, MD James C. Georges-son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State Greek Orthodox 11/9/10 Woodlawn, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ DISSOCTION OF THORACIC ANOUR Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 phys the b attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month ed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, HYPORTONSION 1 Yes 2 No 3 Probably 4 Unknown cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of autopsy death? After this certificate Yes Division of Vital 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) NOSPICE the Funeral Director: After the Tuleted filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of injury 28c. Injury at Certificate: 28d. Describe how injury occurred the Hospital or Attending thin 24 hours after death. Fellwhile TRYING TOSITON ☐ Natural ☐ Accident 5 Pending Investigation HIS BOD 28e. Place of Injury - At home, farm, street, factory, once building, etc. (Specify) PICKE (25GILL 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, determined PICKERSGILL TOWSON, MD within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. D46360

1:28 p M

9. Birthplace (State or Foreign

White

10d. Inside City Limits

Approximate Interval Betwee

Onset and Death

Day

Year

1 🗌 Yes 2 🏝 No

Registrar DHMH 17 Rev 7/2009

State

NOV 08 2010

address of person who completed cause of death (Item 23a) (Type, Print)

NICEOM MO 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34926 For State Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Stella Josephine Gross November 2010 1:00 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Cente Baltimore Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 10/4/192) 9. Birthplace (State or Foreign Country)
Maryland . Age (In yrs. last birthday) **Funeral** 83 Days Hours 1 M 2 SF 216-20-6526 Director Usual Residence of Decedent or 28a-f show notified at 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Baltimore Upperco Mary land 1 🗆 Yes 2 🙀 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be r Funeral 21155 U.S.A. 15753 Dover Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. or i þ 1 Never Married 2 Married 1 ☐ Yes 2 🗶 No If Yes, Give filed within 72 hours after Specify: White 1 ☐ Yes 2 🛛 No Specify: "natural" Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore, Maryland 2121 Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than 'ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Black & Decker Machinists Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Gren Mary Bruce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3204 Paper Mill Road Phoenix, Maryland 21131 Ron Loewe / Friend Department of Healt Important: If item 2 any Injury or other 1 once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖔 Burial 2 🗆 Cremation 3 🗆 Removal from State 11/10/2010 4 Donation 5 Other (Specify) Baltimore, Maryland Holv Redeemer Most 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Fanerat Service Licenses 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of: To the Hospital or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 2 No as been signed by the a 9 Unknown g Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No certificate has page 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No 은 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 XNatural injury 5 Pending work? 1 ☐ Yes 2 ☐ No __ Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 29a. Certifier LEcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 31. Date filed (Month, Day,

NOV 08 2010

TOWSOM, MI

h (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienery For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2010 1800 Physician/ Gensler .CCa Medical City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** General Hos toward olumbia County Howard Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number **Funeral** Hours 3/28/1918 92 NY 113-01-5738 Director Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State within 72 hours after death with the Maryland Director 1 🗆 Yes 2 😾 No **QUEENS** BELLE HARBOR NY 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 11694 IISA 420 BEACH 136TH STREET 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S ural", or iten I Examiner n 11. Marital Status Armed Force Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 💢 No Completed by Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes, Give Specify: WHITE "natural", 3 ☒ Widowed 4 ☐ Divorced Year or Dates. event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event". (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) OWN HOME HOMEMAKER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ SIEGEL GOLD TILLIE MORRIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6905 RAWHIDE RIDGE, COLUMBIA, MD JUDITH DWOSKIN/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 X Removal from State 5 ☐ Other (Specify) 11/4/2010 EMERSON, NJ CEDAR PARK CEMETERY 4 Donation 22. Name and Address of Facility meral Service Licensee SOL LEVINSON & BROS., 1d 2 8900 REISTERSTOWN ROAD, PIKESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ rabra disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): ending physician and use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter in the past 12 months?

1 Yes 2 No Month Day Year for 5 Other (specify) Pregnant at time of death been signed by the a should be detached f 9 I Inknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has autopsy page 2 performed' 1 ☐ Yes 2 ☐ No certificate Yes 2 25. Was case referred to medica Hospital or Attending Physician: 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 🗹 No 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 4 Nursing Home 5 Residence 6 Other (Specify, this funeral 28a. Date of injury (Month, Day, Year) 27. Manne of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral injury work? 1 Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Columbia, Marxland 10 ed 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month -15ie +aines 2010 12:15 AM MC+ober Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hopkms Bayview Medical Cente Baltimor N/A Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days June 21 Year) 937 1 🗆 M 2 😡 F 212-04-8207 England 73 Director Usual Residence of Decedent 23a or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Dunda1k permit. Page 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sl any injury or other traumatic event, the Medical Examiner must be notified. Baltimore MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 Funeral 1925 Oxley Road England 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Housewife 12 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Edward Powell Elsie Pountney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula Haines (Daughter) 21222 8205 Gray Haven Road Apt. F Dundalk, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Denation 2 Cremation 3 Removal from Stat Baltimore, Maryland Garders of Faith Cem! 11/9/2010 Other (Specify) 21. Sign ture Feneral Servi 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Asystole Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner days death Bram Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or linjury Due to (or as a consequence of) days Exami e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

124 hours after death.

Funeral Director. After this certificate has been signed by the attending physician and leted filled in by the funeral director, page 2 should be detached for use as the burial-transit Stroke that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 morths?

1 Yes 2 No
9 Unknown Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \(\subseteq\) Nursing Home 5 \(\subseteq\) Residence 6 \(\subseteq\) Other (Specify) 1 Tes 2 1 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Matural injury work? 1 🔲 Yes 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier 29c. License number REG-000 2010

State Registrar

DHMH 17 Rev 7/2009

4940 Eastern Avenue;

Baltimore, MD

21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar' Signatu

E. Childers, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 28b, f per me, 2909, 11/19/2010dnb Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HEAR D Month 23:52 MARGARET OCTOBER 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death UNIVERSITY OF MARYLAND MEDICAL CENTER BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🕱 F Months Days Hours Min 10/24/1922 218 12 0793 MARYLAND Director 88 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show once. 10b. County 10c. City. Town or Location 10a. State Director 10d. Inside City Limits MD BALTIMORE ROSEDALE 1 ☐ Yes 2🗓 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8059 WOODHAVEN ROAD 21237 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: WHITE 3 X Widowed 4 ☐ Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME 10 HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ ARTHUR PITTS LEE ANNA HOFMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RONALD HEARD/SON P.O. BOX 898 POWAY, CALIFORNIA, 92074 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State OAK LAWN CEMETERY 11/05/10 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral S 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTIMORE, 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final MULTIPLE Physician/ INJURIES disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. E. ter Urdenying Cause (Disease or iinjury Examiner Due to (or as a consequence of): WOMED OF MEDICAL CHANDLES Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 本名3の十二 fox 台下 Division of Vital Records, P.O. Box 68760 THE PARTY OF IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy performed' 2 No Yes 2 No 1 🗌 Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 X Yes 2 🗌 No Other: ၉ 1 Npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 0.708 ER 94,200 12:42 ☐ Natural Accident 5 Pending within 24 hours after deau.

To the Funeral Director: After the funeral on the funeral pay the COLLISION 1 ☐ Yes 2 💢 No MOTOR VEHICLE Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) Severna Park, MD. VETERANS HIGHWAY AND BENPIELD BLUD determined STREET Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier OCTOBER, 29, 2010 RES 000 MD

State

Registrar

MO

22 S. GREENE ST. BALTIMORE, MO 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MANJUNATA
31. Date filed (Month, Day, Year)

NOV 0 5 2010

MARKANDAYA

Certification: To Medical

Completed Be

funeral director, page 2 should filled in by

this certificate

Director:

Hospital or Attending 24 hours after death.

To the Hospital within 24 hours a To the Funeral C

1 □ Yes 4 □ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: All Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1- Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be determined 3 ☐ Suicide

 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier (Check only

ffi Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 ARZIU NOUI,

Ridge Rd Westminster MD 21157

2010

4c. County of Death

1917

Carrol1

USA

domestic

14 Bace - American Indian.

Specify: White

23d. Date of delivery

Day

3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

Month

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1:45p

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 □Yes 2 No

State Registrar

31. Date filed (Month, Day, Year) NOV 08 201

29b. Signature and title of certifier

4 Homicide

one)

32. Registrar's Signature

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Henle Month of Robert 8114 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2656 Brook Valley Rd. Frederick Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Oct. 11, **Funeral** 9. Birthplace (State or Foreign 1 🛣 M 2 □ F Months Days Hours Min Year) Virginia Yrs Director 227-42-6274 1933 Usual Residence of Decedent 28a-f show 10a. State 10b. County traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 X Yes 2 No Frederick Frederick 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral 23a2656 Brook Valley Rd. 21701 U.S.A. filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces?

1

Yes 2

No

If Yes, Give

Year or Dates. 1954-74 Black, White, etc. "natural", or ٥ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify Specify. Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) <u>military career</u> <u>Federal</u> government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Leon Henley permit. Page 1 and 2 should be Department of Health and Meni Important. If item 27 is marke any injury or other traumatic o Ruth Brav 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth H. Henley/ wife 2656 Brook Valley Rd. Frederick, MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) County Cremation | 11/5/2010 Sykesville, MD 21. Sign ur o P neral Service Licer 22. Name and Address of Facility Hartzler Funeral Home at arine 310 Church St. New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Stroke Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Gocer, small cell Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examir the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Live Birth 2 - Fela 300 Pregnant at time of death Yes 2 No Month Dav Year g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No Drostate 1 ☐ Yes 2 No 25. War case referred to medical Be 26. Place of Death (Check only one) examiner Hospital 2 No Other: 1 Yes 유 1 Inpatient 2 ER/Outpatient 3 DOA 4 🗋 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1. Natural iniury 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier within 24 hou

To the Fune

completed fil (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature an D0055061

Registrar

DHMH 17 Rev 7/2009

State

and address of person who complet

300 West Nonth St

ed cause of death (Item 23a) (Type, Print)

MD

AGY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Betty Jane Harris 2010 Medical November 5:00 PM 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 21 S. Benedum St. Union Bridge Carroll Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Aug. 15, **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🔀 F Days Hours Min. Country) Maryland 217-28-5505 78 Director Usual Residence of Decedent 10a. State 10b. County filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director X☐ Yes 2 ☐ No Maryland Carrol] Union Bridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21 S. Benedum St. 21791 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: White Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than ad war.

Al Hygiene.

Ad other thr

s event, thr Elementary/Seconday (0-12) College (1-4 or 5+) Cafeteria Worker Board of Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filed thent of Health and Mental H rant: If item 27 is marked ot ijury or other traumatic ever မ Claude K. Bohn, Sr. Annie Spencer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jack I. Harris/husband 21 S. Benedum St. Union Bridge, MD 21791 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State Department or Important: If any injury or once. Linganore Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 11/08/2010 Unionville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brothers Hartzler Funeral Home Yonde a 6 E. Broadway Union Bridge, MD 21791 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Metastatic Cancer unknown disease or condition resulting in death) months Medical **Examiner** Obstructive hronic Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy Pregnant at time of death Month Day Year 1 Yes 2 V tor: After this certificate has been signed by the the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☑Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Director: After this certificate has performed? Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: 24 hours after death. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death baccurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number odor. B. Nowaval P1112000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Uday B. Nanavaty 224 Washington Heights Westminster, MD 21157 1. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 0 8 2010 Registrar DHMH 17 Rev 7/2009 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ALBERTA MAY HALL HUGGINS 201 d November 1:33 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Greater Baltimore Medical Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗆 F Months Davs Hours Apr 30, Year 938 Maryland 216-32-2210 72 Director Usual Residence of Decedent ortant; If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the <u>Medical Examiner must be notified at</u> 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore County Towson 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 111 West Road 21204 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 M Married 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 6 Homemaker Own Residence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ha11 Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James E. Huggins (Husband) 111 West Road, Towson, Maryland 21204 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State Green Mount Crematory 11/6/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Martin D. Lawson MITCHELL WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Annroximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ PNEYMONIA disease or condition resulting in death) DAYS Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🕱 No Day 1 ☐ Yes 2 🕽 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed? this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 X No ပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After 1 X Natural 5 Pending 1 Yes Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after of Funeral Direct determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D53430 2010 NOVEMBER 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21204

DHMH 17 Rev 7/2009

State

Registrar

CHARLES

STREET

BALTIMORE

MARYLAND

6701

NORTH

32. Registraris Signature

CHAN

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Miriam Agnes Hradsky November 11:41 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Maria Health Care Center Baltimore Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland **Funeral** 1 □ M 2 🔯 F Months Hours (Month, Day, April 9 Director 212-<u>10-0997</u> 95 Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Baltimore Baltimore 1 Tyes 2 X No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 6401 N. Charles Street 21212 U.S.A. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ģ ò 1 X Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha years Teacher Education Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Matthew Hradsky Beatrice Vach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains 6401 N. Sr. Bernice Feilinger, S.S.N.D. Charles Street Baltimore, Maryland 21212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Villa Maria Cemetery 11-9-10 Glen Arm, Maryland 21. Signature of Funeral Service Licensee Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 23a. Part 1. Eyler the Trease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final EUNCUIA Physician/ disease or condition Medical resulting in death) HACK CBSTAUCTIVE PULMENT DISASSE **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Dav Year 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗀 No 1 Yes Hospital or Attending Physician: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 1 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral is 27. Munner 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No. 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Francis X.

31. Date filed (Month, Day, Year,

Carmody

M.D.

32. Registra & Signature

7505 Osler Drive

Towson, Maryland 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dorothy Lee Jenkins Month 2 0°1 0 Nov 10:15A M Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Baltimore Towson Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 02/24/1930 **Funeral** Birthplace (State or Foreign Country) Days 578-40-9254 1 □ M 2 🔀 F **Director** 80 GA Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director MD Howard Columbia 1 Yes 2 No 10f. Zip Code 21046 ō 10e. Street and Number 10g. Citizen of What Country? Funeral 6301 Amherst Ave "natural", or items 23a USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes ※XXNo
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. \$ 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 11 Homemaker Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clifford Schneider Evelyn Sheldon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6301 Amherst Ave Columbia MD 21046 Donald Jenkins/ Husband 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crem any injury or 11/07/201 Glen Bernie MD 21. Signature of Fune al Service Licer ^{22. Name and Address of Facility} Simplicity Crem and Fun Ser ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final abstructive Ph sician/ ron. c Lung disense disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Certificate: To Be Completed by Physician/Medical Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 phys IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 🗆 No 1 T Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DQA 0122 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending after death. 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No. within 24 hours after death

To the Funeral Director: A
completed filled in by the f Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

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State Registrar 6701

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Registrar's Sign

address of person who completed cause of death (Item 23a) (Type, Print)

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

November 6, 2010

N. Chales St. Bolto. Md 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / De State of Maryland / De Registrar	partment of Hea ertificate of Dea			ene g. No. 201	10 34936		
	Physicia		Decedent's Name (First, Middle, Last) John Malcolm Kelley			2. Date of Death		3. Time of Death 5:34 P M		
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Loc	cation of Death	4c. County		f Death		
أمهد			3138 Hernwood Rd.	Woodst				timore		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 1 XM 2 F 7 Yrs.		Under 24 Hrs. lours Min.	8. Date of Birth (Month Day)	563	Birthplace (State or Foreign Country) MD		
	nd now	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	ocation				10d. Inside City Limits		
	farylar Ba-f sl	Director	MD Baltimore Woo		1 ☐ Yes 2 🏝 N					
	the N a or 28	Ē	10e. Street and Number	10f. Zip Code		10	10g. Citizen of What Country?			
	th with	Funeral	3138 Hernwood Rd.		163		USA			
_	or iter	by Fu	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Never Married 2 ☐ Married 11. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No	 Was Decedent of Hispan If Yes, specify Cuban, M 	nic Origin? (Spe lexican, Puerto I	cify Yes or No- Rican, etc.)		- American Indian, White, etc.		
213-0038	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2XXX No S	pecify:		Specify: White			
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yland	e filed ttal Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)	18.		(First, Middle, Ma	,			
	ould be id Men marke matic	[John Paul Kelley 19a. Informant's Name/Relationship (Type, Print) 19b. Ma	Was Add a 40		ie Teresa Owings				
Z Z	d 2 shoalth an alth an 27 is		7 7 7				mber, City or Town, State, Zip Code) ock, MD 21163			
saitimore,	of Her of Her If item		20a. Method of Disposition 20b. Place of Dis	position (Name of rematory or other place)	_			City or Town, State		
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 0	permi Depar Impoi any in		21. Signature of Funeral Service Licensee	22-Name and Address of Burrler Que	een ^{ty} Fund	eral Home	e & Cren	matory, P.A. d, MD 21784		
ı			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.					Approximate Interval Between		
~-	nysician/ Medical	8 8	Immediate Cause (Final disease or condition resulting in death)			Onset and Death				
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2	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affact death. Of the Funeral Director, Affact this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical Examiner	d							
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POX 0	ath cer attend for use	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Live Birth 2 ☐ Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date Montl	· ·		
٥ ک	the de by the ached	hysi	1 Yes 2 No 4 Pregnant at time of death 5							
Ţ.	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death: within 24 hours after death: completed filled in by the funeral director, page 2 should be detached for use as		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in	n Part I.	23e. Did tobacco use contribute to the cause of deat				
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Į.	sian: T ertifica ctor, p	Be C	25. Was case referred to medical examiner?	26. Place o	of Death (Check	-	No 1L	Yes 2 No		
<u> </u>	Physic this or	은	1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpat 27. Manner of Death 28a. Date of injury 28b. Time			me 5 Residen		(Specify)		
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Division of	r Atter ter dea rector	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	- 2	28f. Location (Stre	n (Street and Number or Rural Route Number,			
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	ne Hos n 24 h ne Fun pleted	Medical	(Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, deat only one) 3 Certifying Nurse Practioner: To the best of my knowledge	estigation, in my opinion, de	eath occurred at	the time, date and	place, and due to	o the cause(s) and manner stated.		
	Vith Vith Com		29b. Signature and title of certifier	29c. License nun	mber	29	d. Date signed (/	Month, Day, Year)		
			30. Name and address of person who completed cause of death (Item 23a) (Type		7799		November	- 5, 2010		
			Edward Allan Racela Sison							
	Stat Registra		31. Date filed (Month, Day, Year) 3. Registrar's Signature	arted						

P.O. Box 68760, Division or Vital Records,

that the death certificate be executed physician nse the ò page 2 certificate funeral director, After this spltal or Att.
4 hours after deati.
reral Director: At within 24 hours at the

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within 72 hours after death with

2 should be filed within and Mental Hygiene.

Health and

permit. Pages 1 and 2 Department of Health a Important: If item 27 Is

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

erson who completed cause of death (Item 23a) (Type, Print)

Eachern Avenue Raltimore MD 21224

2. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dav Month LEWIS VIOI A 10: 10 2010 Medical 4a. Facility Name (if not institution, give street and number)

UMM S Ball more 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Balhmac Ballimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 1 🗆 M 2 🎗 F Months Days Min 29.32.9235 71 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimere Dikesville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Weyanoke 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🔀 No If Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Holistic Health 12th grade 6 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Gambrillist. liola Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chemit Weranoke Court Dikesville MD 21208 Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Avbutus Cemetent Baltimore, 09/2010 4 ☐ Donation 5 ☐ Other (Specify) C. Greene Tuneral Sonica 21. Signature of Funeral Service Licensee 22. Name and Add s of Facility Variation 8728 Liberty - Road Randallotown NO 2113 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death ₽hysician*ı* SEPSIS disease or condition Medical resulting in death) Urinary trad infection **Examiner** sequentially life conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the tuneral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Leval Failure 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pending 2 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🗠 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DOU 70226 11/5 2010 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print green street

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State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#18,19a, perFH, G909, 11/8/2010, WS.
State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2234 Nov Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death University of Mariland Baltimore Medical Center N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Funeral 6. Sex 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Min. 1 ★ M 2 □ F 218-44-3963 65 Director 194 Sept MD Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County N/A 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland 10d. Inside City Limits Director Baltimore 1 🙀 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5501 Cedonia Avenue 21206 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ★Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify. permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) General 12th N/A Assemblv Line Motors 18. Mother's Name (First, Middle, Maiden Surname) **Blackwon**Zelma Blackmon 17. Father's Name (First, Middle, Last) John Lindsay other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5501 Cedonia Ave Balto., MD 21206 19a. Informant's Name/Relationship (Type, Print, Jasnice Lindsay?Wife Lindsay Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Arbutus Mem Pk any injury or 11/13/10 Arbutus, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Betts Funeral Home 1129 N. Caroline St. Balto., MD 21213 ucia 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ₽nysiciam/ Anoxia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 4 hours Kespirator Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of Hepatic attending physician and for use as the burial-transit WEEKS law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 🗌 No ed by the a g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed I , page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed Yes 2 Hospital or Attending Physician: The certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ရှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending injury work? 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of exemination and/or inventionable in my action death. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 223317 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7+1 5+. Baltimore MD ZIZOI 22 S. Greene 31. Date filed (Month, Day, Year) 32. Registrar's Signature ark Registrar

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Olivia Kala ancas 2010 1948 7 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland Raltinere If Under 1 Year | If Und Baltimere Cit Medical Birthplace (State or Foreign If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Numbe Date of Birth (Month, Day, **Funeral** Year) 1 M 2 KF Months Days Hours Min. Meryland Director 22 10/27/2010 infant Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits show 10a. State id other than "natural", or items 23a or 28a-f showevent, the Medical Exeminer must be notified at 1 Yes 2 No Director Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21239 USA 1650 E. Belvedere Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Maryland 21215-0036 black 1 ☐ Yes 2 🔀 No Specify. 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) infant infant infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vianca Clark ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tra 22 S. Green Street Bsltimore, MD University of Md Medical Center Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Injury o 4□Donation 5\Other(Specify) in state 21. Signature of Funeral Service Licensee Ronald S. Wede, Director

State Anatomy Board 655 W. B

Baltimore, MD 21201

23a. Par 1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, short or want failure. List only one cause on each line. State Anatomy Board 655 W. Baltimore Street Immediate Cause (Final **Physician** extreme disease or condition resulting in death) prematuraly /Medical Due to (or as a consequence of): Examiner placental abruption Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): attending physician for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ icate has been sig , page 2 should b 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No certificate 2, **N**0 Division of Vital 1 ☐ Yes 1 ☐ Yes Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t 28b. Time of 28d. Describe how injury occurred After 28c. Injury at Work? 1 Natural 5 Pending Injury 1 ☐Yes 2 ☐ No 2 Accident investigation completely filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 🎉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature 29d. Date signed (Month, Day, Year) 29c. License number R18270 30. Name and ss of person who completed cause of death (item 23a) (Type, Print) 2 South Green Street Baltimore, mo 21201

DHMH 17 Rev 1/2001

State

Registrar

32. Registrar's

082010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nov . ∠^{Day} 2010 7:40 A M Ronald T. Leaverton Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Dellwood Court Hunt Valley Baltimore . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Mary Land Hours Director 213-44-9223 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🕱 No Maryland Baltimore Hunt Valley 10e. Street and Number 10g. Citizen of What Country? Funeral 21030 23 Dellwood Court U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 X Yes 2 If Yes, Give Black White etc 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. 3 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Radio & Television Elementary/Seconday (0-12) College (1-4 or 5+) Commercial Firm President Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas Robert Lvle Leaverton Bettv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cockeysville, Maryland 21030 Dellwood Court <u>Patricia Leaverton</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

21. Sig 3 are of Fareral Service Licensee Hilltop Service Corp. 11-6-2010 Towson Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Vai 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCARDIAL Physician/ INFARCTION disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** HYPERTENSION Sequentially list conditions, Examine Directo for as a consequence of: cause. Enter Underlying Cause (Disease or linjury physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) /Medical I Division of Vital Records, P.O. Box 68760 attending ph I for use as th IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 D Unknown been signated Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an or Attending Physician: The law has autopsy perform death? certificate 1 ☐ Yes 2 ☒ No Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 🗷 Residence 6 Cher (Specify) 2 🔀 No ည 1 Inpatient 2 ER/Outpatient 3 DOA in 24 hours after death.

The Funeral Director: After the pleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation
6 Could not be 1 Yes 2 No 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 📈 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier npleted f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) (im Kull D64307 5 2010 NOVEMBER

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(P)

State Registrar AVE

21229

LIPTA) OOF

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VITBERF

31. Date filed (Month, Day, Year) NOV 0 8 2010

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NOV. 2010 **ABRAHAM** LACHOWSKY 2, 2:30 P M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Birthpiec Country) NY **Funeral** 1 XX 2 - F Months Days Hours Min. Month Day Year, 5/8/1928 106-22-1708 Director 82 Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD MONTGOMERY GAITHERSBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 12 BATTERY BEND COURT 20886 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 XXIo
If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: WHITE 3 XXidowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) BOOKBINDER PRINTING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည MORRIS LACHOWSKY MOLLIE ROBLANSKY 19a. Informant's Name/Relationship (Type, Print)
BARBARA KRISS / DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, $12\ BATTERY\ BEND\ CT;\ GAITHERSBURG,\ MD\ 20886$ 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XXurial 2 Cremation 3 Removal from State injury or BETH MOSES CEMETERY 11/4/2010 4 ☐ Donation 5 ☐ Other (Specify) PINELAWN, NY SOL LEVINSON & BROS., 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 8900 REISTERSTOWN RD; BALTIMORE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ ASTATIC disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner DENOCARCINOMA Couperitally list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Month Dav Year Pregnant at time of death is certificate has been signed by the director, page 2 should be detached 9 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Division of Vital Records, 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an yes 2 N 1 ☐ Yes 2 ☐ No B B 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 X No Other: ည 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at Natural 5 Pending work 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D

completed filled i Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number OSCIENTI (Item 23a) (Type, Print) -D. 6121 MONTRESE RO, ROCKVILLE M.D. Registrar's Signat

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State Registrar

10-08359 UNK UNK

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		I- For State Registrar		Cert	ificate c	f De	ath			Re	g. No.		_
Physicia		Decedent's Name (First, Middle,Last)											3. Time of Death
Medical Exami		Evelyn E. Morales							1	Month Day Year 1649 hrs			
		4a. Facility Name (if not institution	n, give street and n	umber)		4b. Cit	y, Town, or Lo	cation of I				inty of Death	
		Route 131 South of La	angmaid Road			Ne	wark				Word	cester	
5	-	5. Social Security Number	6. Sex	7. Age (In yrs. las	st birthday)	I If U	nder 1 Year	If Under 2	24Hrs. 8	B. Date of Birth	n (MM/DD/Y	YYY) 9. Bin	thplace (State or Foreign
Funeral Director						Мо	nths Days	Hours	Min.			Co	untry)
Director	L	125-54-3965	1 M 2XF		48 Yr	S.				04/27	/1962	Pue	erto Rico
_	L	Usual Residence of Decedent 10a State 10b County 10c City, Town or Location 10d. Inside								10d. Inside City Limits			
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and sho	ь	NY	Bronx					ronx					
daryland 28a-f show 1 at once.	Director	10e. Street and Number				10f.	Zip Code			10	g. Citizen of What Country?		
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		3 Widowed 4 Div	orced If Yes, Give Ye		1 🔀	Yes	2 No	specify: $^{ m P}$	uert	o Rica	n Spec	cify: W]	hite
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36 hin 7 than	흵	9					Homer	naker		Нс			hold
5-0036 led within Hygiene. other tha	탉	17, Father's Name (First, Middle, Last) 18.Mother's Name						Name (Fi	e (First, Middle, Maiden Surname)				
11215-0036 Id be filed within 72 hours after fental Hygiene. narked other than "natural", event, the Medical Examiner.	Be	Victor Manu	el Mora	les				Aida	S	ocorro	Orti	z Soli	S
	0	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailir	ng Addr	ess (Street	and Numbe	er or Rura	al Route Num	ber, City or	Town, State	, Zip Code)
MD 2 nd 2 shoul lith and M m 27 is m aumatic	-1	Carmelo Doming	uez. Jr.	(Son	879	Mad	ev Plac	e. B	ronx	, New	York	10455	
	ŀ	20a. Method of Disposition	,	20b. PI	ace of Dispo	sition (l	Name of ceme	etery,	D	ate		tion - City or	Town, State
of H fright	- 1	1 X Burial 2 Cremation	n 3 Removal	IIOIII State	ematory or o				Nov.	-	_		
Pag ment		4 Donation 5 Other S	pegify)	st.			Cemet		20	10	Bron	ix, Nev	w York
Baltimore, permit. Pages 1 ar Department of Her Important: If ite		21. Sunature of Funeral Service	Licensee	\mathcal{Y}	22.	Name a	and Address o	of Facility	Sta	llings	Fune	eral Ho	ome, P.A.
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Physician	-	failure. List only one cause on each lin. \ Between Onset a										Between Onset and	
Examiner	- 1	Immediate Cause (Final Issease a. Multiple Injuries									Death		
_xammer	- 1	or condition resulting in death)	Due to (or as	a consequence of)									
	L	Sequentially list conditions,	b			_					_		-
	<u>e</u>	if any, leading to immediate cause. Enter Underlying Cause		a consequence of)	:								
	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of)	:								
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cath certifications as for use as	<u> </u>			gnant at time of dea	th 5 (Other (S	Specify)				1		
Box 68 e death certificate attending ed for use as	Ş	1 Yes 2 No 9 ✔ Un	3 Oliki	nown									
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COT law has l	림									perfor	med?	death?	
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Vital Rec ysician: The l his certificate director, page	Be	25. Was case referred to medical examiner?	Hospital:				26.Place o					0 000	- 0
hysi al dir	ပ္	1 ✓ Yes 2 No		<u> </u>	ER/Outpatier			ther ₄		d. Describe h		6 Othe	r: Scene
Division of Vital Records, ral or Attending Physician: The law requirers after death. a) Director: After this certificate has been sided in by the funeral director, page 2 should the company of the funeral director, page 2 should the funeral director.		27. Manner of Death 1 Natural 5 Page	Nov 1	e of Injury th, Day Year) 2010	28b. Time of 1644 hrs	rinjury	28c. Injury		lP:	assenger a			
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VIS or A ther or A in by	띭	3 Suicide 6 Cou	ild not be	ace of Injury - At hor	me, farm, str	eet, fact	tory, office bu	ilding, etc.	1.0	or Town St	tate)		ıral Route Number, City
Divis ospital or At hours after d ineral Direc	Certification:	4 Homicide	ermined (Specifi	Major Road	/ Highwa	у			Ro	oute 131 Sou	uth of Lan	gmaid Roa	id, Newark, MD
Hos 24 h Fun rtely		29a. Certifier 1 Certifying P	hysician: To the b	est of my knowledge	e, death occ	urred at	the time, date	e and place	e, and du	e to the cause	e(s) and ma	anner as stat	ed.
To the Hos within 24 h To the Fur	Medical	one) 2 Medical Exa	aminer: On the basis	s of examination an stated.	d/or investig	ation, in	my opinion,	death occu	urred at tr	ne time, date a			
F 3 F 3	ž	29b. Signature and title of certifi		1			29c. License						inth, Day, Year)
		(alun	W	1	J		O.C.M	I.E.			Novem	ber 2, 20	10
		30. Name and address of person	n who completed ca	use of death (Item :	23a)								
			Assistant Med			nn St	reet, Baltir	nore, M	D 2120)1			
	tate	31. Date filed (Month, Day, Year,	32.1	Registrar's Signatur	e	,	2						
Regis		NOV 9 8	3 2010 4	Annes o	Ai 33	M. C.	2					001	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dorothy Davidson Physician/ Nov. 3, 2010 Mark 1342 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Montgomery 4b. City, Town, or Location of Death Examiner Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Social Security Number 6 Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏻 F Hours 009-14-7853 83 1 MANT, Pay 19926 Vermont Director Usual Residence of Decedent fshov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at be filed within 72 hours after death with the Maryland Director MD Silver Spring Montgomery 1 🗆 Yes 2 ื No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 20904 12104 Jan Lane USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? 1 ☐ Yes 2 ☐ No Black, White, etc. . or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give "natural", 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Eonce. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Clerical 12 Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Randall Clifford H.Davidson 19a. Informant's Name/Relationship (Type, Print)
Frank F. Mark/Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12104 Jan Lane Silver Spring, Md. 20904 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗆 Burial 2 🖾 Cremation 3 🗆 Removal from State Chesapeake Crem. 11/08/2010 Beltsville, Md 4 Donation 5 Other (Specify) 21. Signature of Funeral Se PHILIPADES RENALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resp atory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician Cervical spine fracture disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖺 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an the Hospital or Attending Physician: The law s certificate has blirector, page 2 s performed? Yes 2 No 1 Yes 2 No **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes Other: 힏 2 No 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 10 28 7 201 0 work? 1 ☐ Yes 2 🔀 No 1545 Fall Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
OUTSIGE BUSINESS 28f. Location (Street and Number or Rural Route Number City or Town, State) University Silver Spring, Md. determined Medical 29a. Certifier Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0066414 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (entr Dr. Ste 309 7525 Greenway Schechur, no 32 Registrar's Signature 31. Date filed (Month, Day, Year) NOV 0 8 2010 State Registrar

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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Lois J. Morton NOVEMBER 2010 2:15AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltmiore Baltimore Hospital Social Security Number 9. Birthplace (State or Foreign Country) W. VA 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth Funeral 1 □ M 2 💢 F 216-34-6914 70 1(Month, 1933(ear) Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Completed by Funeral Director MD n/a Baltimore 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 3501 Grantley Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🔀 No Specify: Specify: African-American 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) 12th <u> Iandan Foe</u> Seanstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Robert Coleman Larcenia Kessler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) atientknown 3506 Mary Vale Road Windsor Mill, MD 21244 Mary F. Collins/Sister 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Veteraris 11-15-2010 Owings Mills, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. RNAGO 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) as a consequence of) Examiner 2 weeks neumoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) g physician and as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of). resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 signed by the attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been si rector, page 2 should Obstendine pulmo nary 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an mone Hag 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No the funeral director, Be 26. Place of Death (Check only one) Hospital: Other ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined 1 🗸 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the basis of my knowledge, death accorded to the time, date and place and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Novembu 3 2010 Laxmi 18009 30. Name and address of person who completed cause of death, (Item 23a) (Type, Print) MD: Smai Hospital of baltuno 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 08 2010 Registrar

Morton

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 34948 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Elmer James Morgan, Sr. November 2010 5:50 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Stella Maris Hospice Center Timonium 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Feb. 27, 1925 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 ☑ M 2 ☐ F Yrs Director 218-12-9457 85 Marÿland Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified Dundalk 1 Yes 2 No MD Baltimore 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral 21222 1706 Ranch Lane United States death v 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. , o à 1 Never Married 2 Married 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 🖾 No Specify: Completed 3 X Widowed 4 Divorced Specify. White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Agent Insurance 12 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Page 1 and 2 should be nent of Health and Ments Dolly Gray Ernest Morgan 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other tra Mr. Elmer James Morgan, Jr. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 11/9/2010 Baltimore, Maryland Oak/Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign fure uneral Serve Licens any in ²² Duda-Ruck Funeral Home of Dundalk, Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) CONGESTIVE HEART FAILURE Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) physician and the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Dav Pregnant at time of death Yes 2 No 9 Unknown g 🗌 Unknown P.O. To the Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No Records, 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 X No 1 Yes 2 🗌 No Yes of Vital completed filled in by the funeral director. 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) 2 X No Other: 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗶 Natural 5 \square Pending Division 1 🗌 Yes 2 🗌 No ☐ Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 🗌 Homicide determined City or Town, State) within 24 hours a Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year, 2010 person who completed cause of death (Item 23a) (Type, Print) JONES. CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

Registrar
DHMH 17 Rev 7/2009

State

a.m.

5:50

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NOVEMBER

ELMER MORGAN

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Ctober Medical Alan Mackza 4a. Facility Name (if not institution, give street and numbe **Examiner** City, Town, or Location of Death 4c. County of Death naryland timore Social Security Number Age (In yrs. last birthday) 8. Sate of Birth **Funeral** 9. Birthplace (State or Foreign Country) unk 1 🕅 M 2 🗆 F Hours Min July 6, 1955 55 **Director** 219-66-4641 Usual Residence of Decedent 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits items 23a or 28a-f s ner must be notified MD 1

Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1217 W. Fayette Street 21223 USA unk Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or ite Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married unk 2 No Baltimore, Maryland 21215-0036 ☐ Yes 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced If Yes, Give white Specify: Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education unk 16b. Kind of Business Industry (Specify only highest grade completed) th and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) unk unk 18. Mother's Name (First, Middle, Maiden Surname) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh ment of Health ar tant: If item 27 is Maryland General Hospital 827 Linden AVenue Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🗓 Other (Specify) in state Ronald S. Wad State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician/ neumonia disease or condition resulting in death) Medical Du to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Yes 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No မ 1 🗌 Inpatient 2 🕽 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 15503 molunulacen OCTOBER 29 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMATIN W NAEEM 501 DOLPHIN STREET BALTIMORE MD 21217 31. Date filed (Month, Day, Year) Registrar's Signat State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nownth 4:00 A M Cathy P. Nolton 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2201 Cherokee Dr. Westminster Carroll 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country)
 CT **Funeral** 1 ☐ M 2🌠 F Months Days Hours Min 272/1943 Director 67 044-34-6017 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Completed by Funeral Director 1 ☐ Yes 2 X No MD Carrol1 Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2201 Cherokee Dr. 21157 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2XXNo Specify: 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) il Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other the Substance Abuse Counselor D.C. Salvation Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Thomas Francis Purtell Marjorie Wenzel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Robert M. Nolton/Husband 2201 Cherokee Dr., Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2XXCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Crematory 11/2/2010 Winfield, MD . Signature of Forteral Se ²²Burrier-Queen Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ SCVL disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death the 9 Unknown Unknown been signed by should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy nerforme Osteo/ordan 1 Yes 2 No Yes 2 No 25. Was case referred to médical examiner?

1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🕊 Residence 6 🗀 Other (Specify) Hospital: မ 1 Inpatient 2 I ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No after death

Director: A

d in by the f Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours aft

To the Funeral Di

completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number

DHMH 17 Rev 7/2009

State Registrar Juite 126

Ellicot Cets. Md21042

30/Name and address of person who completed cause of death (Item 23a) (Type, Print)

Doncy Hall

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-08436 State of Maryland / Department of Health and Mental Hygiene Bryan John Ninosky Certificate of Death 1- For State Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ 1134 hrs John Ninosky November 4, 2010 Brvan Medical Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Howard 8358 Montgomery Run Road, Apt. F Ellicott City 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year if Under 24Hrs. 5. Social Security Number 6. Sex **Funeral** Country) Hours Months Days MD June 13 1974 36 220-92-0239 X_{M} Director 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 X No MD Howard Ellicott City s 23a or 28a-f show a permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28æ-f sho Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 8358 Montgomery Run F 21043 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11 Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married 2 X No 1 Yes specify: white 1 Yes 2 X No specify: If Yes. Give Year 3 Widowed 4 Divorced ≥ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) finance 21215-0036 financial consultant 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ellie Peden Joseph J. Ninosky Be traumatic event, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9 Village Gate Ct., Owings Mills, MD 21117 2 Michael Ninosky (brother) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) 1 Y Burial 2 Cremation 3 Removal from State 11-8-10 Sykesville, MD Springfield Cemetery Donation 5 Other Specify 22. Name and Address of Facility algnt uneral home & Chapel 21. Signature of Funeral Service Licensee P.O. Box 195 Sykesville, MD 21784 Parge Haight I erbert 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician **Between Onset and** failure. List only one cause on each line. Death Madical a. Asphyxia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical AMENDED UNPENDED for use as the burial -Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Day 2 Fetal death Month 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown n signed by the a d be detached fo 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown ğ Completed s certificate has been si rector, page 2 should b 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed?

Yes 2 V No death? 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be Other Nursing Home 5 Residence 6 🗸 Other: Scene examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 this 1 Yes ဥ 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred After the 28b. Time of Injury 27. Manner of Death Subject inhaled helium gas Certification: Nov 4, 2010 0000 hrs 1 Yes 2 V No 1 Natural 5 Pending Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 🗹 Suicide

Division of Vital Records, P.O. within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

> Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar Signatur arka

(Specify) Single Family Home

and manner stated.

6 Could not be

2010

4 Homicide 29a. Certifier 1

29b. Signature and title of certifier

Zabiullah Ali, M.D.

31. Date filed (Month, I

Medical

determined

Name and address of person who completed cause of death (Item 23a)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Will Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E

or Town, State) 8358 Montgomery Run Road, Apt. F, Ellicott City, MD

November 6, 2010

29d. Date signed (Month, Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener) 34950 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month November 02 2010 7:30 Рм Dorothea Neus Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Maples of Towson Towson 5. Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign 1 M 2 D Maryland Months Days Hours Min Director 91 216-01-4050 1919 show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Timonium Md. Baltimore 1 Yes 2 XNo 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Completed by Funeral 21093 1901 Northleigh Rd. USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 CaWidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Adiuster Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Velenofsky Frank Wimmer, Sr. Marv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Peter Neus/ Stepson 1901 Northleigh Rd. Timonium, Md. 21093 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, 11-4-10 Hilltop Service Co. Towson, Md. 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 21. Signature of Fyneral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Vance disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as consequence of Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 🔀 No
9 ☐ Unknown Pregnant at time of death Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 2 No Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital ၉ 1 🗌 Yes 2 X No Other: 4 Nursing Home 5 Residence 6 A Other (Specify) ALF 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 K Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined **Medical** Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 ho

To the Fune (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0061485 A220M1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Bushra I. AL-Azzawi, M.), 9103 Franklin Sp. Dr. Suite 301, Rose dale, MD 21237

DHMH 17 Rev 7/2009

Registrar

31. Date filed (*Month, Day, Year*) **NOV 08 2010**

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Drothea

Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death V Month when Day 5 Physician/ Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 MM 2 □ F Months (Month, Day, Director Usual Residence of Decedent or 28a-f show th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Numb 10f. Zip Code 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☑ Yes 2 ☐ No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Completed 3 Widowed 4 Divorced MITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Nymber or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sł Department of Health a Important: If item 27 is any injury or other tra Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) -10 uneral crvi 21. Sign vivre of 23a) Part 1. Enter the disease, or complications, or heart failure. List only one s that caused the death. Do not enter the mode of dying, such as cardiac or Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Kena Ph sician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit requires that the death certificate be executed Cause (Disease or iinlury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Box 68760 as the IF FEMALE: nse yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Live Birth 2 - Fetal death Ectopic pregnancy ò in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death should be detached P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by Vostate Records, 2 No 3 Probably peen 24b. Were autopsy findings available 24a. Was an the Hospital or Attending Physician: The law certificate has page 2 prior to completion of cause of death?

1 Yes 2 No autopsy perform Yes 2 **Division of Vital** the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 ☐ Pending _ Investigation Natural work? Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. a cause(s) and marries 29d Date signed (Nonth, Day, Year) 29b. Signature and title of certifier 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAIDR. GEORBE 31. Date filed (Month, Day, Year) State NOV 08 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Betty Prinkey November 2010 5:00 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7328 Ge<u>ise Avenue</u> Baltimore Co. Edgemere 5. Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 22. Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 ☐ M 2XEXTF Director 214-26-4422 80 Fèb. 1930 Pennsylvania Usual Residence of Decedent than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Edgemere 1 Tes 2 X No MD **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7328 Geise Ave. 21219 United States 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Completed 3x Widowed 4 □ Divorced Specify White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Years Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Robert Kelly Ida Sines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William E. Prinkey, III (Son) 2125 Reuter Road Timonium, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Addison Cemetery Onation 5 Other (Specify) 11/8/2010 Addison, PA 21. Signatu of Funeral Service Licensee, Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or, ach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Medical resulting in death) Due to (or as a consequence of Examiner rongry Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequent attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Year Pregnant at time of death Day signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 res 2 No 3 Probably 4 Unknown roidism 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suint 1 Natural 5 Pending work?
1 Yes in 24 hours area and the Funeral Director: Af 2 🗌 No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

State

only one)

29b. Signature and tiple of certific

Registrar

DHMH 17 Rev 7/2009

who completed cause of death (Item 23a) (Type, Print)

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

North Pt. Bro #732 Batimore, M. ZIZZ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of N	Maryland		artment of		and M	1ental Hy		10	34954
	Physicia		1. Decedent's Name (First, Middle	Rodey		001	imeate of	Death		Date of De Month	Day	Year	3. Time of Death
, m	Medi Examir		4a. Facility Name (if not institution, Harber He	give street and number,			4b. City, Town,	ltim	of Death	Novem	4c. County	2010 of Death N/2	3:35 PM
	Funeral Director		5. Social Security Number 217-62-9508 Usual Residence of Decedent	6. Sex 1 □XM 2 □ F	Age (In yrs. last		If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Bir (Month, Da Feb. 1	th y, Year) 2 1953	9. Birthp Coun	place (State or Foreign try) MD
	Maryland 28a-f show otified at	Director	10a. State 10b. County Maryland Anne	Arundel	10c. City, ⁻	Town or Loc		hicum		-		1	0d. Inside City Limits 1 ☐ Yes 2x No
	h with the ns 23a or nust be n	Funeral D	10e. Street and Number 332 Double Eag	le Drive			10f. Zip Code	2109	90		10g. Citizen of \	What Coun	try?
9800	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	2	11. Marital Status 1 ☐ Never Married 2 ☐ Marr 3 🔀 Widowed 4 ☐ Divorced	If Yes, Give Year or Dates.	?		/as Decedent of H Yes, specify Cub			cify Yes or No- Rican, etc.)		e - Americ k, White, e	
Maryland 21215-0036	and 2 should be filed Health and Mental Hy em 27 is marked oth ther traumatic event	e Completed	Elementary/Seconday (0-12)	College (1-4 or 2	Completed) College (1-4 or 5+) College (1-5 or 5+)			dent's Usual Occupation kind of work done during most of working O NOT use retired) Correction Officer			16b. Kind of Business Industry State of Maryland		
ryland		To Be	17. Father's Name (First, Middle, La Donald H.	Rođey				Est	er	Smit	Maiden Surname :h)	
			19a. Informant's Name/Relationsh Erin Fultz 20a. Method of Disposition	(daugh	ter)	l Sa	g Address (Street		La.	, Sever	n MD 21	144	
Baltimore,	t. Page tment tant: h ijury or		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	pecify)	e cem	etery, crem 1. Have	ition (Name of atory or other pla n Cemete	ery	Nov. 20	10		rnie,	Maryland
Ba	Depar Depar Impor any ir	l. Va	21. Signature of Funeral Service Li	24 C)			Name and Addre	ıntain	Road	d, Pasa	dena, M	al Ho	me, P.A. 22
-1	nysician/ Medical	. 0	23a. Part 1. Enter the disease, or of shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	nly one cause on each lif	ed the death. L	1	the mode of dyir	Orce	cardiac or	respiratory arm	est,		Approximate Interval Between Onset and Death
	be executed cian and conial-transit	Sequentially list conditions, if any, leading to immediate b. Disable to (or as a consequence or):											
0		dical Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c. Obe	a consequence	ce of):							
8760	rtificate ing phys e as the	Medi	IF FEMALE:	d									
). Box 687	ne death cer / the attendii ched for use	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 1 Victorial Pregnant Victorial Pregnancy 1 Victorial Pregnant Victorial Pregnancy 1 Vict								23d. Date Mor	e of deliver	y Day Year
rds, P.O.	To the propriat or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Completed by P	Part II. Other significant condition	ns contributing to death I	out not resultir	ng in the un	derlying cause giv	ven in Part I.			es 2 No		cause of death?
Division of Vital Records,	Pnysician; The law r r this certificate has b aral director, page 2 sh		25. Was case referred to medical							24a. Was a autops perfor	med? p		sy findings available pletion of cause of
Vita	nysicia his cert il direct	10 B	examiner?	Hospital:	ient 2 ER/	Outpatient	0.11	ace of Death er: 4 \(\sum \) Nun			ence 6 🗆 Other	(Specify)	
sion of	death. ctor: After t t the funera	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investiga 3 Suicide 6 Could no	ation of be	y, Year)	o. Time of injury		/ at	28 No	d. Describe ho	w injury occurred	1	
Dİ <u>Xİ</u>	pural or A burs after eral Direc filled in by		4 ☐ Homicide determin 29a. Certifier 1 Certifying F	building, et	c. (Specify)		,,		90	City or Town	,		
:	ithin 24 h	Med	Concor 2 - Wiedical Ex	Physician: To the best of aminer: On the basis of elurse Practioner: To the	examination and	d/or investid	ation, in my opinio	n, death occ e time, date a	urrod at th	e time, date an and due to the	d place, and due cause(s) and man	to the caus ner as stat	e(s) and manner stated. ed.
	- 3 - 0)		10		29c. License	0674	12	7 /	9d. Date signed Vovembe		2010
	Charles		30. Name and address of person when the state of the stat	no completed cause of d	Sour	a) (Type, Print	inover i	Street	, Bo	altimor	e MD		225
	State Registra	_	NOV 08	2010 Sens	a s signature	10 4	antel						

DHMH 17 Rev 7/2009

10-08230 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Curtis Nolan Ridgeway State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day October 25, 2010 Medical Examiner idgeway 1655 hrs olar 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 6120 Moorefield Road Catonsville **Baltimore County** 5. Social Security Number 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 6 Sex **Funeral** Months Days Hours 152 - 48 - 153 Director 1 V M 2 F Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No or items 23a or 28a-f shormust be notified at once, Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code Funeral 14. Race - American Indian, Black, 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc 1 Never Married 2 Yes If Yes, Give Year 1 Yes 2 No specify: 3 Widowed 4 Divorced ģ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) d other than ", timore, MD 21215-0036 Z 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) marked (Street and Number or Rural Route Number, City or Town, State, Zip Code) atonsv116 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition 2 Cremation 3 Removal from State tment o Memnial Donation 5 Other Specify. 21. Signature of Funeral Service License 22. Name and Address of Facility Funero Heighta Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as a track or respir flory arrest, shock, or hear Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Hypertensive cardiovascular disease Death xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed AMENDED **27,28a-f oer me,g911,01/12/2011dhb** 23a,PII,27,28a-f,per ME G910 12/21/10 Physician/Medical X UNPENDED the attending physician ed for use as the burial -G910 12/21/10 of Vital Records, P.O. Box 68760, IF FEMALE: 23d, Date of delivery 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? has been signed by 2 should be detach ģ 1 Yes 2 No 3 Probably 4 V Unknown Remote gunshot wound of neck with complications Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No certificate 1 🗸 Yes Hospital or Attending Physician: '24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Be Other₄ examiner? Nursing Home 5 Inpatient 2 ER/Outpatient 3 Residence 6 V Other: Scene After this 1 V Yes 2 No 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? To the Hospita. ... within 24 hours after death.
To the Funeral Director: Af Certification: Subject was shot Natural Division Yes 2 X No 5 Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Anchor Hocking park unit ing lot, city of Salem, NJ At home, farm, street, factory, office building, etc X Could not be Suicide 4 X Homicide determined (Specify) unkin parking lot Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) W. O.C.M.E November 3, 2010

State

32. Jegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

Ling Li, MD

Registrar

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 1556 PM William L. Rheubottom October 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimole Agnes Hospital Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 8. Date of Birth (Month, Day, Year) Aug 10 1929 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Min. 1 X M 2 □ F Aug 218-26-9547 Yrs 81 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show MD XYes 2□No Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 0 USA 21229 405 Long Island Ave Apt A Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. N Yes 2 No If Yes, Give Year or Dates: 52-54 1 Never Married 2 ☐ Married 10 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black Specify: þ 3 Widowed 4 Divorced natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Crane Operator 12 Department of Health and Mental Hygie Important: If item 27 Is marked other I any injury or other traumatic event, In once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hilda Brown Unavailable ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 405 Long Island Ave Apt A Baltimore MD21229 Hazel Frierson/Companion 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/29/10 Glen Bernie MD Atlantic Crem 22. Name and Address of Facility Simplicity Cremation&Fun ThomasAllenPA 7090 Ridge Rd HanoverMD 21. Signature of Funeral Service Licensee ThomasAllenPA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Aspidation **Physician** Pay disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Renal failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be execute physician and s the burial-trans Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐Yes 2 ☑No 1 ☐Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier truman 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Caton Avenue Nadipell Raltimore.

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

OV 08 2010 General B. Spares

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 for State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death November 4, 2010 Physician/ Edward Henderson Richardson Jr 12:15P Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner None Baltimore Roland Park Place If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 **XX**M 2 □ F 1272471971 Marv1 and 219-30-3701 98 Director Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County filed within 72 hours after death with the Maryland Director XX Yes 2 No Baltimore Maryland None 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 830 West 40th Street 21211 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) e 1 and 2 should be filed within 72 l t of Health and Mental Hygiene. If item 27 is marked other than "r or other traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Medical Surgeon Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Emily Gould Edward Henderson Richardson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 220 Stoney Run Lane #B2 Baltimore, Maryland 21210 Edward Henderson Richardson 3rd Son 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or ot 11/06/2010 Baltimore, Maryland GreenMount Crematory □ Donation 5 □ Other (Specify) nature of Funeral Serve 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) umonia N - Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury the attending physician and hed for use as the burial-tran that initiated events Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be exec resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Mellitus 2 No 3 Probably 4 Unknown 1 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No Yes 2 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မှ 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 6301 N. Charles 8 onnell ms

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

32. Registraris Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34958 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Mildred V. Rossbach 8:50 A.M Nov Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Days Sept. 23,1924 Hours Min. 1 M 2 X F Mary land 213-20-6598 **Director** Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director Freeland Baltimore 1 🗌 Yes 2 🛛 No MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21053 United States Funeral 3341 Baker School House Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 XXNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3 😾 Widowed 4 🗆 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Medical Records Rosewood 12th and Mental Hygie is marked other Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Gleason ပ Nellie William J. Offutt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a, Informant's Name/Relationship (Type, Print) Freeland, MD 21053 3341 Baker School House Road item 27 Ellen Davis Daughter any injury or other 20b. Place of Disposition (Name of cometery, crematory or other place)
Lake View Mem. Park Nov. 8, 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite 1XXBurial 2 Cremation 3 Removal from State Sykesville, MD 2010 Donation 5 Other (Specify) 22. Name and Address of Facility
Burrier-Oueen Funeral Home & Crer
1717 W Old Liberty Road Winfield 21. Signa e of Funeral Service Lonses Crematory PA eld. MD 21784 23a. F rt 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s ock, of heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immed ate Cause (Final diseas or condition resulting in death) Ph_sician/ - Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Cause (Disease or illingury that initiated events resulting in death) Last anding physician and use as the burial-transit Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ned by the atten edetached for u in the past 12 months 5 Other (specify) Pregnant at time of death Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sate has been signed page 2 should be det þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 2 🗆 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner ol ath 28b. Time of 28a. Date of injury 28d. Describe how injury occurred Certificate: (Month, Day, Year) the Hospital or Attending 1 Latural 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H0062165 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500Upper Chisapeake Kurtom 31. Date filed (Month, Day, Year) NOV 08 2010 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #11, per FH 9909 11/12/10 TT State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician М 2010 TINNE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 12/2/48 Birthplace (State or Foreign Country) 5. Social Security Number . Age (In vrs. last birthday **Funeral** 1**X** M 2 □ F 212-48-0712 61 NC Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County show or 28a-f shown notified at N/A Baltimore 1 X Yes 2 □ No MD Director 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number ō 21206 an "natural", or items 23a o Medical Examiner must be USA 5014 Frankford Ave Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. African Was Decedent Ever in U.S Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after unent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or ite 1 Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Warried 2X No 21215-0036 1 ☐ Yes 2X No Specify. \$ 3 Widowed 4 Divorced America Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Omni Hotel Cook the 12 18. Mother's Name (First, Middle, Maiden Surname) traumatic event, 17. Father's Name (First, Middle, Last) Baltimore, Maryland Be Ramona Sanders James H. Stinney, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5014 Frankford Ave., Balt., MD 21206 Tontalia Stinney/Daughter permit. Pages 1 and 2:
Department of Health a
Important: If item 27 is
any injury or other trau 20a. Method of Disposition

✓ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Zion Cem. 20c. Location - City or Town, State Date 11/13/10 Balt.,MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hari, P. 21. Signature of Fu jeral Service License 22. Name and Address of Facility Hari P. Close F.Svs, PA 5126 Belair Rd, Balt., MD 21206-5105 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 21 Due to (or is a consequence of) /Medical **Examiner** rmoni Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed X and the burial-tra resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical ast attending IF FEMALE nse s 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 ☐ Yes 2 ☐ No for Pregnant at time of death 5 Other (specify) detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? been signed be self Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has 1 Yes 2 No 1 Yes 2 No certificate 25. Was case referred to medical examiner? To the Hospital or Attending Physician: 26. Place of Death Check only one funeral director, Be Other: $4 \square$ Nursing Home $5 \square$ Residence $6 \square$ Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury М 1 ☐ Yes 2 ☐ No r death. 2 Accident the within 24 hours after deati To the Funeral Director: completely filled in by the Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide City or Town, State) 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certif DIMA who completed cause of death (Item 23a) (Type, Print) 30. Name and address of d 600 North Wolfe St, Baltimore, MD, 21287 NSEL Registrar's Signatur

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 08

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Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No .-1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Doris Virginia Stuller :54P 2010 Medical Nov 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Manchester Longview Nursing Home ecurity Number 92 If Under Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 F Months Hours Min. 05/16/1925 Country) Director 219-14-965 85 MD Usual Residence of Decedent ian "natural", or items 23a or 28a-f show Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 X Yes 2 ☐ No Westminster Carroll MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21157 225 Frock Drive Apt. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?.
1 ☐ Yes 2 No Black. White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) ĝ 10 Sales Retail Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) မှ Mary Berwager <u>Archie Tucker</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 225 Frock Dr. Apt 119, Westminster, Md., 2115 James Stuller-husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1📈 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Silver Run Mary's Cem 11/9/2010 ignatur of ral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home t. Westminster,Md. 21157 254 Main Ε. St 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine cause. Enter Underlying attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 5 Other (specify) been signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performed? Yes 2 KN After this certificate s after deam.
ral Director: After this cer.... 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 No ျှ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Pranticinan To the best of my knowledge, death occurred at the time, date and place, and one to the within 2 only one 29b. Signatur 30. Name 31. Date filed onth, Day, Ye r. 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Allen David Smith 2010 November 12:38a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Carrol1 Westminster 5. Social Security Number Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Oct 18 1927 Hours 1 X M 2 □ F 83 Director 212-26-6048 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Ellicott City 1 🗆 Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2920 Woodwick Court 21042 USA 12. Was Decedent Ever in U.S. Armed Forces?

1. Yes 2 No 1945
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) banking bank manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frances Dontell Columbus Leroy Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2920 Woodwick Ct., Ellicott City, MD 21042 Marguerite Smith (spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Olivet Cemetery 1 X Burial 2 Cremation 3 Removal from State 11-10-10 Frederick MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel Signature of Funeral Service Licenses Poug K erbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death P_M sician/ disease or condition Medical resulting in death) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death). Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Tho 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s autopsy performed' death? 2 🗌 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Herica examiner? Other (Specify) Justinat 10 Hospital Other 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town. State within 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) // O mpleted cause of death (Item 23a) (Type,

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year

Registrar's Signature

10-07819 Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Anna Stevens 2010 34962 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Medical Examiner 1834 hrs Anna Stevens October 11, 2010 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death 2311 Garrett Avenue **Baltimore** Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** 85 Months Days Hours Min. Feb 19 Director Country Carol 220-22-3739 1 M 82 Yrs Usual Residence of Deceden N A 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Y Yes 2 No MD Baltimore permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country 2311 Garrett AVenue 21218 USA **23**a Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces White, etc. 1 Never Married 2 Married 1 Yes 3 X Widowed Divorced If Yes, Give Year 4 1 Yes 2 X No specify: à black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) is marked other than atic event, the Medical Baltimore, MD 21215-0036 0 housekeeping hospitals 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Otis Pierce Virginia Daniels ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt: If item 27 i Nadine Johnson/daughter 1228 Linkside Drive Parkville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State y or oth Donation 5 X Other Specify: in state ure of Funeral Sur ce Licensee ²² Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death a. Hypertensive Cardiovascular Disease Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine naise Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical UNPENDED attending physician or use as the burial AMENDED #7,8,perINF,G910,12/7/2010,WS Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) g 1 Yes 2 V No 9 Unknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Ş 1 Yes 2 No 3 Probably 4 ✔ Unknown Diabetes Mellitus Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy this certificate has performed' death? Yes 2 V No Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene 1 Yes 2 No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred Certification 1 V Natural filled in by the fi 24 hours after death. Funeral Director: Pending 1 Yes 2 No Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined Homicide 29a. Certifier 1 (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical within 2 To the 1 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated: 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 20, 2010 30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

31. Date filed (M

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32. Registrar's Signature

111 Penn Street, Baltimore, MD 21201

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Daniel Smith Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Baltimore Union Memorial Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year Jan 21, 1 Funeral 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Months Min. Days Hours 1 ₹ M 2 □ F Country) unk Director 43 215-96-1719 1967 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director MD Baltimore TX☐ Yes 2 ☐ No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 1206 Union Avenue 21211 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status traumatic event, the Medical Examiner 14. Race - American Indian. þ unk Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Completed 3 ☐ Widowed 4 ☐ Divorced black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation unk unk 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) unk of the stand of the stand of the standard of the stand of the stand of the standard of the sta Be unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Union Memorial Hospital 201 E. University Pkwy Baltimore, MD injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1. Department of I Important: If ite any injury or of ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 □ Donation 5 tx Other (Specify) in state Ronald S. Wade 21. Sign ture of [22. Name and Address of Facility tate Anatomy Board 655 W. Baltimore Street rector MD 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis Physician. disease or condition day Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): death certificate be executed that initiated events physician ar s the burial-to resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 use as t attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Year Day ed by the a P.O. signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? 1 Yes 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) 1 Yes Other: 2 No ၉ 1X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Louising Nurse Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier AT 2438946 MI

Registrar DHMH 17 Rev 7/2009

State

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31. Date filed (Month, Day, Year)

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201 E. University Parkway, Baltimore. MD 21218

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MMH

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ November 2010 12:20 PM IRIS WOODWARD CHILDS SEWARD Medical 4a. Facility Name (no cientific poives ree MAY 97 be HAPEL Examiner 4b. City, Town, or Location of Death 4c. County of Death 12230 Roundwood Road #214 B Timonium Baltimore County Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 16. **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🗶 F Months Min Maryland Director 217-16-1961 1922 88 Usual Residence of Decedent 28a-f show r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore County Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 USA 12230 Roundwood Road within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Auto Agency Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Ford Dorothy Middleton J. Childs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Morn Mist Court, Baltimore, Maryland 21234 Melissa S. Diehl (Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other placel injury 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem Grans 11/9/2010 Timonium Maryland Martin D. Lawson TCHELL-WIEDEFELD FUNERAL HOME, INC. 00 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that dauser the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each 11/2. Interval Between Onset and Death Immediate Cause (Final Physician Rulli disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or import that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director After this certificate has been along the second to the Funeral Director. attending physician and for use as the burial-trans Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown Month Day Year Pregnant at time of death ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 1 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🛱 No Other: မြ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident 1 Yes 2 No Investigation 2 Accider
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Registrar DHMH 17 Rev 7/2009 29b. Signature and title of certifie

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

US

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** _03 2010 40 /Medical November 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore

Hinder 1 Year | If Under 24 Hrs. Morningside House of Satyr Hill Baltimore Birthplace (State or Foreign Country) Age (In yrs. last birthday, 1 Year Days 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Funeral Months Min Hours 1□M 2☑F 90 218-03-1392 Director Sept 11. 1920 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Funeral Director Md. Baltimore Baltimore 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code or Items 23a or 8800 Old Harford Rd. 21234 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Black White etc 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify Specify White Completed by 3√ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Data Entry Fleet Leasing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Peter Meadow Sophia Olhanowska 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Joseph F. Meadow/ Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 4804 College Ave. College Park, Md. 20740 Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-5-10 Towson, Md. Hilltop Service Co. 22. Name and Address of Facility
Ruck Towson Funeral Home, 21. Signature of Fyrral Frvice Livensee 1050 York Rd. Towson, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1112000 /Medical Due to (or ma a consequence of) Examiner N 2000 Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner 2000 Division or Vital Records, P.O. Box 68760, $\mathcal F$ burial-trar Due to (or as a consequence of): physician IA the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown ģ signed b 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 🔲 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has , Anema Somna 2 No 1□ Yes Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 No death. 2 Accident the within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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/32. Registrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0-06423 Vinslow Thoma	is	State of Maryland / Department of Health and Mental F		Jible.	01000
		1- For State Crivial yland / Department of Freath and Wentair Registrar Certificate of Death		2010 eg. No.	34967
Physici Medical Exam		1. Decedent's Name (First, Middle Last)	2. Date of Death	h Day Year	3. Time of Death 2116 hrs
Ne circuit		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea	November	3, 2010 4c. County of Death	
		University Hospital Baltimore		N/A	}
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 153-60-4225 1 X M 2 F 1 Yrs. 1 Houter 1 Year If Under 24H 4 Yrs. 1 Months Days Hours Mi		h(MM/DD/YYYY) 9. Birt Foreig Cou	
		Usual Residence of Decedent	J KII. I	1,1100	"" /Waryima
d 10w any C.		Maryland N/A Baltinore			10d. Inside City Limits 1 X Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Coun	
with the Maryland ns 23a or 28a-f sho be notified at once.	I Dir	4508 Shanrock Avenue 21206		United St	tates
eath wir items.	Funeral	11. Manital Status 1 Never Married 2 Married 2 Married 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Solution of Hispanic Origin?) 15. Was Decedent of Hispanic Origin? (Solution of Hispanic Origin?) 16. Was Decedent of Hispanic Origin? (Solution of Hispanic Origin?) 17. Was Decedent Ever in U.S. 18. Was Decedent of Hispanic Origin? (Solution of Hispanic Origin?) 18. Was Decedent of Hispanic Origin?	Specify Yes or No- to Rican, etc.)	14. Race - Americ White, etc.	can Indian, Black,
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5-0036 lled within 72 he Hygiene. I other than "n: the Medical Ex	Completed	12 Kesidential Couns	selor	Kesidentia	1 Juality
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	Be Cor	17. Father's Name (First, Middle, Last) Nomas, St. 18. Mother's Nam Office	ne (First, Middle, M	aiden Surname)	
imore, MD 2121. Pages 1 and 2 should be fill ment of Health and Mental I tant: If item 27 is marked or other traumatic event,	To E	19a. Informant's Name/Relationship (Type, Print) Tyrese Thomas - Wite 4508 Shamrock Avi	r Rural Route Numb	ber, City or Town, State,	Zip Code)
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MOF Pages I nent of I int: If		1 K Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: MI). National Celebratory	2010	Laurel	
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		21. Signature of Funeral Service Licensee 22. Name and Address of Familia N			
Physician	\dashv	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	or respiratory arres	St. shock, or heart	Approximate Interval
Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Injuries with complications			Between Onset and Death
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Box 68760, i death certificate be he attending physici d for use as the buri	ian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregn	nancy		ay Year
Box e death the atter ed for u	Physician/Med	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown			
ires that the signed by the detache	by P	Part II. Other significant conditions contributing to death but not resulting in the undertying cause given in Part I.		pacco use contribute to the	
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_ = . ↑ 4		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury Coche Injury 28b. Time of Injury 28b. Time of Injury 1600 hrs 1 Yes 2 No	28d. Describe ho Subject assau	ow injury occurred ulted	
Division pital or Attendio ours after death.	Certification:	3 Suicide 6 Could not be determined (Specify) Light Rail Station	28f. Location (Str or Town, Sta	reet and Number or Rura ate) man Street, Baltimore	al Route Number, City
Division To the Hospital or Attency within 24 hours after death To the Funeral Director:		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and	d due to the cause((s) and manner as stated	d.
To the within To the complet	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. 29b. Signature and title of certifier 29c. License number		nd place, and due to the 29d. Date signed (Mont	
		o.c.m.e. och		November 4, 2010	
	ŀ	30. Name and address of person who completed cause of death (Item 23a)			
	2/0	Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimor 31. Date filed (Month, Day, Year) 32. Registrar's Signature	re, MD 21201		
	.) (.)	or. Date filed (Mortin, Day, read)			

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of N	/laryland / Dep			nd Mental Hy	- 001	0 21000	
			Registrar 1. Decedent's Name (First, Middle, Last)	Ce	ertificate o	f Death		Heg. No.	0 34968	
	Physicia Medic		Norman E. Tyson				2. Date of De Month	Day Year		
	Examin		4a. Facility Name (if not institution, give street and number)			n, or Location of	Death	4c. County of Death		
4.00			Holy Cross Sanctuary			onsville		Montgomery		
	Funeral Director		5. Social Security Number 6. Sex 183−14−9580 1 M 2 □ F 7. A	ge (In yrs. last birthday 88 Yrs.	Months Day	ys Hours	Min. 8. Date of Bir Month, Da Dec 7	y, Year) C	lirthplace (State or Foreign Country) INSV1vania	
	To Mo and	,	Usual Residence of Decedent				7 200			
	rryland	Director	10a. State 10b. County MD Howard	10c. City, Town or I					10d. Inside City Limits	
	or 288	Dire	MD Howard 10e. Street and Number	Clark	sville			10g. Citizen of What (1 Yes 2 No	
	filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at.	Funeral	11850 Tall Timber Drive		101. 245 000	21029		USA	Sound y?	
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036	s after al", or Exami	d by	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates.	142-45	1 ☐ Yes 2 🌠	No Specify:		Specify: wh	·	
2	hours natur dical	olete	15. Decedent's Education	16a. Dec	edent's Usual Occ	cupation	fdia	16b. Kind of Busines	s Industry	
21	hin 72 ne. than " ie Me	Completed	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or	lifo	e kind of work dor DO NOT use retire	ed)	r working			
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lan	e 1 and 2 should be filed with of Health and Mental Hygien If item 27 is marked other the other traumatic event, the	2	Chester Julian Tyson				Bertha Hau	,		
ary	should and N is ma		19a. Informant's Name/Relationship (Type, Print)	19b. Ma	iling Address (Stre	et and Number	or Rural Route Numbe	er, City or Town, State, 2	Zip Code)	
Σ 	and 2 stealth		Norman E. Tyson Jr/son	<u> </u>		d Drive	Annapolis	, MD 21401	-	
Baltimore, Maryland 21215-0036	Page Tent Int:		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify)	e 20b. Place of Disposer	oosition (Name of ematory or other p	olace)	Date	20c. Location - City (or Town, State	
Balt	permit. E Departm Importa any inju		21. Signature of Luneral S		State and Add Baltimore		ard 655 W 1201	. Baltimore	Street	
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20 X	ending r use a	an/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome 1 ☐ Live Birth	e of pregnancy 2 Fetal death 3	☐ Ectopic pregna	ancv		23d. Date of d	elivery	
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ls, P.O.	requires that the death certific been signed by the attending I should be detached for use as	Completed by Physician/M	Part II. Other significant conditions contributing to death	but not resulting in the	underlying cause	given in Part I.		obacco use contribute Yes 2 No 3 No	to the cause of death? Probably 4 Unknown	
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ř	n: The ficate or, pag		25. Was case referred to medical		000	Discos of Doobs	1 🗆 Yes		es 2 No	
VIta	ysicia s cert directe	To Be	examiner? Hospital:	tient 2 🗆 ER/Outpati		Other:	ing Home, 5 Resid	dance 6 C Other (Spe	nifel	
n ot	nding Phy tth. : After thi e funeral		27. Manner of Death 1 Natural 5 Pending (Month, December 2) Accident Investigation	ury 28b. Time	of 28c. In	tt 3 □ DOA				
Division of Vital Records,	al or Atter s after des l Director d in by th	Certificate:	3 Suicide 6 Could not be 28e. Place of Inj	jury - At home, farm, s tc. <i>(Specify)</i>	treet, factory, office	ce		on (Street and Number or Rural Route Number, Town, State)		
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of only one) 3 Certifying Nurse Practioner: To the	examination and/or inve	estigation, in my op	inion, death occu	rred at the time, date a	ind place, and due to the	cause(s) and manner stated.	
	To the within To the complete	_	29b. Signature and title of certifier Assure Last	Osai 2		nse number		29d. Date signed (Mon		
	'		30. Name and address of person who completed cause of o	death (Item 23a) (Type,	Print) Print)	+ AVE	BACIT	Mn 21	289	
8	Stat Registra	e ·	31. Date filed (Vorth, Pa 2010) 32. Registr	rar Signard AL		. , , , , ,	, .			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician/ 2010 Virginia Lee Via Nov Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carroll Westminster Carroll Hospice Dove House 9. Birthplace (State or Foreign 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** Country) Days Hours Min 1 M 2 X F MD 76 Director 215-32-8200 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location e 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f shown other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County Director 1 Yes 2 No Westminster Carroll 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 21157 350 N. Colonial Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) ဂ္ Dorothy Bolte Clinton B. Warrener 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Westminster, Md 21157 1605 Exeter Road, Kathy Boone-daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1
Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 11/9/2010<u>Sykesv</u>ille 4 Donation 5 Other (Specify) Lakeview Mem. 22. Name and Address of Facility Fletcher Funeral Home 21. Signat Furnisa Survice Licensee 254 E. Main Street Westminster, Md. 21157 rease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician/ mus disease or condition Medical resulting in death) to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner g physician and as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 5 Other (specify) Pregnant at time of death ate has been signed by the page 2 should be detached 91 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 A Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🚹 No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 No Other: 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, ျ eral Director: After thi filled in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certificate: injury 1 Natural 5 Pending Investigation Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d To the Funeral Direct completed filled in by 1 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one and title of certifier 29b. Signatur 0/0

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

death (Item 23a) (Type, Print)

2. Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month Betty E. Vaden 10:58PM 2010 ez November Medical 4a. Facility Name (if not institution, give street and number, ·Examiner 4c. County of Death N/ATown, or Location of Death 0 Saltimore Baitmore Itospital of 7 If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year)
May 1939 7. Age (In vrs. last birthday) If Under 9. Birthplace (State or Foreign **Funeral** 216-36-4567 1 🗆 M 2 🕱 F Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a, State death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore N/A 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2020 Featherbed Ln 21207 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 Yes 2 No Specify: Completed 3 X Widowed 4 Divorced Q 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Provident Bank Knaun Customer Service Rep 12th N/A Be permit. Page 1 and 2 should be fliec
Department of Health and Mental Hy
Important: If item 27 is marked oth
any injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cleveland Blackmon Elizabeth McGriff 19a. Informant's Name/Relationship (Type, Print)
Karl Vaden/Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4113 ロナガナ Kathland Ave. Balto., MD 21207 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Woodlawn Cemetery 11/10/10 Woodlawn, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Lune al Service Licensee 1129 N. Caroline St. Baito., MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ everc disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) or the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

The Funeral Director: After this certificate has been signed by the attending physician and impleted filled in by the funeral director, page 2 should be detached for use as the burial-transit. resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year 1 Yes 2 L 9 Unknown 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 Mo Hospital Other: ျှ 1 Npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann of Death Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatur RES-00 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai tospital of tonia State

Registrar

			T = For State Registrar	Olato of Ma	Ce	ertificate			10 111		Reg. No.	010		349	71
	Physici /Medi		Decedent's Name (First, Middle, Last MACY	st)	WILL	LAM.	S			2. Date of De Month	Day	Year 201	.	3. Time of 2.(00)	·
	Examir		4a. Facility Name (If not institution, give 8104 Del Haven F	•		4b. City, 7		Location of	Death		-	County of Dea		Co	
	Funeral Director		5. Social Security Number 6. S 213–36–1365		(In yrs. last birthdaj Yrs.			If Under 24 Hours	Min.	8. Date of Bir (Month, Da June 19	th ay, Year)	9. Bi	rthplac o <i>untry</i>	e (State o and	or Foreigi
	Maryland a-f show ifled at	ctor	Usual Residence of Decedent 10a. State 10b. County MD Baltim	nore	10c. City, Town or I								10d.	Inside Ci	
	with the	Director	10e. Street and Number 8104 Del Have	n Pond		10f. Zip	Code	21	222			en of What C			
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the M. clical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	ver in U.S. 13	. Was Deced If Yes, spec			222 n? (Sper Puerto F	cify Yes or No Rican, etc.))- 1	ited S 4. Race - Am Black, Whi Specify:	erican	Indian,	
Maryland 21215-0036	within 72 ho giene. r than "natur the Midical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 12 Years	lucation ide completed) College (1-4or 5+) (Giv	edent's Usua re kind of wor. DO NOT us Homema	k done a e retired	ation luring most o)	of workin	g		nd of Business Wn Home	/Indus		
land	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the M	To Be C	17. Father's Name (First, Middle, Last) Thomas Robert W							(First, Middle	, Maiden :	Surname)			
	and 2 shou ealth and N n 27 Is mai ier traumal		19a. Informant's Name/Relationship (Elizabeth Herrer		l l							Town, State,	•	nde)	
Baltimore,	Pages 1 and the surt. If Item		20a. Method of Disposition 1X☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification of the content		20b. Place of Disposer cometery, cr					²⁰¹⁰		cation - City of			1
Balti	permit. Departrr Importa any inju		21. Signature of Funeral Service Liber	1 This	D	22. Name and uda-Ru	Addres	s of Facility unera	1 Hc		Dunda	alk, In			
	Physician /Medical		23a. Part1. Enler the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line a. SEPS(he death. Do not e							iana 2	Ap	oproximate terval Bette nset and D	ween
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. CHPON I (Due to (or as a	consequence of):					Malhe	PENTINES		1	Mo	NTH
68760,	icate be executed physician and s the burial-transit	cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. RHEUN Due to (or as a	consequence of):	ART	HK	MACH		CAE BLANDING			5	4 41	25
P.O. Box 68	ath certif ittending or use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome p 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death 3	□Ectopic pre					2	3d. Date of de Month	elivery Da	iy \	Year
Records, P.	w requires that the de been signed by the s should be detached f	by	Part II. Other significant conditions of				use give	en in Part I.		23e. Did 1		se contribute t ¶No 3□F		eause of d	
al Reco	nysician : The law r nis certificate has be I director, page 2 sh	Completed								24a. Was auto perfo 1□ Yes	psy ormed?	24b. Were a prior to death?	compl	findings a etion of ca	available ause of
· Vital	Physician: r this certifica ral director, p	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatien	t 2 ☐ ER/Outpatio	ent 3 □ DO	Othe	r'		(Check only		☐Other (Spi	ocifu)		
Division or	Attending Pl death. ctor: After the the funeral	Certification: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day)	Year) 28b. Time Injury	of 28	Bc. Injury Work) F	8d. Describe	how injury	occurred	<u></u>	oute Num	nber.
2	e Hospital or A 124 hours after e Funeral Dire letely filled in b		4 Homicide determined	HONE	(Specify)				8	City or To	wn, State) L HA	EN PD	, BA	LTMBO	
	e Hosi 24 ho e Fune letely f	dical	29a. Certifier (Check only one) Certifying Ph 2 ☐ Medical Exam	ysician: To the best of niner: On the basis of and manner stat	examination and/or	investigation,	in my o	ie, date and pinion, death	piace, a occurre	and due to the	cause(s) date and	and manner a place, and du	s state le to th	ed. e cause(s	s)

State Registrar

1 - For State

Jenniier Hayashi 31. Date filed (Month, Day, Year) NOV 0 8 2010

30. Name and all dress of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

5505 Hopkins Bayview Circle Balto., MD 21224
32. Registrar's Signature

D62032

29c. License number

29d. Date signed (Month, Day, Year)

NOVEMBER

22010

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 6.48 PM Shamar Williams 2010 10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death FRANKLIN Square Rosedal HOSPITal Baltimore If Unde Year If Under 24 Hrs. Funeral 8 Date of Birth 9. Birthplace (State or Foreign 1 ₹ M 2 □ F Months Oct 29, 2010 Director Maryland infant Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location with the Maryland Director 1 Yes 2 No MD Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 811 Jeanette Drive USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, þ 1 Never Married 2 Married Yes 2 No Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: black Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygien is marked other t infanr infant infant infant Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Shae Williams Maria C. Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Franklin Square Hospital 9000 Franklin Square Drive Rosedale, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🗓 Other (Specify) in state 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Previability Prematurity disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner deliver Preterm Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or limitury that initiated agents Due to (or as a consequence of): Exami that initiated events resulting in death) Last Due to (or as a consequence of): anding physician a Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No ☐ Pregnant at time of death☐ Unknown Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Tes 2 🖸 No မှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural iniury 5 Pending work? Accident
Suicide 2 🗆 No Investigation 6 Could not be

Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760 Records, **Division of Vital** within 24 hours after death

To the Funeral Director; A

completed filled in by the 1

hamar

3

D47792 11-02-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

London MD 9000 FRANKLIN Square DR Balto md 21237 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 08 2010

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical

4 Homicide

29a. Certifier

(Check

only one

determined

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Tochelson Year 2010 Day 6:30 A M November 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Woodstock 3516 Hernwood Road Baltimore If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year 8. Date of Birth 6. Sex 1 **X** M 2 □ F 7. Age (In yrs. last birthday) (Month, Day, Year) 11-30-1952 213.50.058 Months Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Woodstuck 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 3516 Hernwood 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian,

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

Physician/

Medical

Examiner

Funeral

Director

items 23a or 28a-f show her must be notified at

Funeral Director

death with the Maryland

Exa		1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑.No If Yes, Give Year or Dates.	1 🗆 Yes 2 🔀 1	No Specify:		Specify: WHITE							
Medical	Сощріете	15. Decedent's Edu (Specify only highest grad Elementary/Seconday (0-12)		16a. Decedent's Usual Occ (Give kind of work dor. life. DO NOT use retire	e during most of work d)	ring I	Kind of Business Industry.							
	as I-	12th grade	N/A	Own	er.		Company							
event,		17. Father's Name (First, Middle, Last)				ne (First, Middle, Maide	n Surname)							
atic ev	<u>ا</u>	Ellis Yochelson			Sally	Witt								
er traum		19a. Informant's Name/Relationship (Type Cathy Yoch & Son	1 / / .	19b. Mailing Address (Stre 3516 Hernwa										
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any inj once,		21. Signature of Funeral Service Licenses		8728 Libe	My Road F	andalbta	ne Flineval Service In MD 21133							
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Z · ctc	<u>ë</u> [27. Manner of Death 1 Natural 5 □ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of 28c. In injury	jury at ork?	28d. Describe how inj	jury occurred							
2 E	2	2 Accident Investigation	, , , , ==,, , ==4,7		Yes 2 No									
	ii Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, street, factory, office	е	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ate)							
	месіса	(Check 2 Medical Examination	er: On the basis of examination	ledge, death occured at the ti n and/or investigation, in my or y knowledge, death occurred a	inion, death occurred a	at the time, date and pla	ice, and due to the cause(s) and mann							
3		29b. Signature and title of certifier		29c. Lice	nse number	29d. [Date signed (Month, Day, Year)							
) Cal			40541		11/4/10							
		30. Name and address of person who co Sack 31. Date filed (Month, Day, Year)	200 Ea	st 334 St	rect Su	ute 501 1	Balto; MD 21218							
			32. Registrar's Signal	ture										
State		S1. Date filed (World, Day, Tear)	A AF	to a Mail										
State gistrar		NOV 0 8 2010	Cerewa B	garde										

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Erick Tomas Mu		Alvarado 1- For State	S	tate of Maryl		epartment <i>Certificate</i>			id Mental I	Hygiene		2010	34974
Physicia		Registrar 1. Decedent's Nam	ne (First, Midd	fle,Last)		Certificate	OI Dec	<i>au i</i>		2. Date of D	Reg. No. Death		3. Time of Death
Medical Exami		${\tt Eric}^{\sf k}$			Munoz	z Alv	arad	lo		Month Octobe	Day r 21, 20	Year 10	1337 hrs
ku.		4a. Facility Name (Rt 228 Bern		on, give street and not of Rt 229	iumber)			, Town, oi Idorf	Location of Dea	th		County of Do Charles	eath
Funeral		5. Social Security I	Number	6. Sex		yrs. last birthday		nder 1 Yea		_			Birthplace (State or
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ά		Usual Residence of 10a. State	f Decedent 10b. County		10c.	City, Town or Lo	cation						10d. Inside City Limits
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Maryla 28a-f	Director	10e. Street and Nu		- 1			10f. Z	Zip Code			1 -	zen of What C	
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hours a	ed by		, ,	or Dates: ecify only highest gra			dent's Usu most of w	al Occupa	tion (Give kind o	f work done	16b. l	Kind of Busine	ss/Industry
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Tent: If item 27 is marked other than "natural", or items 23s or 28s-f show any or other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Sec			1-4 or 5+)			-	ion wor	ker			ruction
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Baltimore, permit. Pages I ar Department of He Important: If ite		4 Donation 5											
Physician 23a. Part I. Enter y edisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List physician are such as a contract of the second of the sec												ICE,P.A. ing.Md20910	
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المر ا		or condition resulting		Due to (or as	a consequer	nce of):							
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Box 68760, e death certificate be extite attending physician ed for use as the burial	Physician/Medic	23b. Was decedent past 12 months		'	birth nant at time		Fetal deat	,	Ectopic pregr	nancy		Month	Day Year
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that the d	by P	Part II. Other signi	ficant condit	ions contributing t	o death but	not resulting in th	e underlyir	ng cause g	given in Part I.		_		to the cause of death?
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Vital Records, ysician: The law requii his certificate has been s director, page 2 should	Completed									au pe	topsy rform <u>ed</u> ?		to completion of cause of
l Re		25. Was case refer	red to medica	1		-		26.Place	of Death (Check	1 Ye	s 2 N	1 🗸	Yes 2 No
Vita ysicia	To Be	examiner?	2 No	Hospital: 1	Inpatient 2	ER/Outpatie	ent 3	DOA	Other Co	ing Home 5	Reside	nce 6 🗸 Ot	her. Scene
on of anding Phath. After the funeral		27. Manner of Deat 1 Natural		28a. Date Oct 21,	of Injury n. Day Year) 2010	28b. Time of 1330 hrs	of Injury		ry at Work? /es 2 No	28d. Descrit Pedestria		by motor	vehicle
Division of Vital Records, P.O. pital or Attending Physician: The law requires that th ours after death. eral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be deach	Certification:	2 🗸 Accident 3 Suicide	6 Coul	d not be		At home, farm, st		ry, office b	uilding, etc.	or Town	, State)		Rural Route Number, City Waldorf, MD
spi hou ner y fill		,		hysician: To the be miner: On the basis	st of my know	wledge, death oc	curred at the			d due to the ca	ause(s) and	d manner as s	tated.
	Medical	29b. Signature and		and manner s				9c. Licens					Month, Day, Year)
33		Ca	1,1	e HA	20	011		O.C.I	M.E.			ober 22, 20	,
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		Carol Allan,		sistant Medical					ore, MD 2120	01			
Sta Registi	ite rar	31. Date filed (Men	CT 25	2010 2	egistrar's Sig	griature.	Nes!						

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State of Maryland / Department of Health and Mental Hygiene

James E Amoid		1- For State	e of Maryland / De C	epartment o Ce <i>rtificate</i> o			ivientai F	-	201(eg. No.	34975					
Physicia		1. Decedent's Name (First, Middle,L.						2. Date of Dea	ith	3. Time of Death					
Medical Exami	ner	James Edwar						Month October 1		1700 hrs					
		4a. Facility Name (if not institution, g Southern Maryland Gene			4b. City,		ocation of Deat	:h	4c. County of De Prince Geo						
Funeral		Social Security Number 6.	Sex 7. Age (In y	rs. last birthday)	If Und	ler 1 Year	If Under 24Hr	s. 8. Date of Bi	rth(MM/DD/YYYY) 9.	Birthplace (State or					
Director		578-18-8349	XM 2 F	88 y	rs. Monti	ns Days	Hours Min	^{n.} 11/1:	3/1921 F°	reign Country) D.C.					
any		Usual Residence of Decedent 10a. State 10b. County	100 (City, Town or Loc	ation					10d. Inside City Limits					
* .			eorge's	Sity, Town or Eco		tlar	nd			1 X Yes 2 No					
tarylan Sa-f s	Director	10e. Street and Number			10f. Zij	Code		1	0g. Citizen of What C	ountry?					
the M 32 or 2		4021 Meadowvi	ew Drive			207	46		USA						
-death with the Maryland or items 23s or 28s-f show must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent Ever in Armed Forces?	n U.S. 13. V	Vas Deced Yes, spec	ent of Hispa fy Cuban, I	anic Origin? (S Mexican, Puert	Specify Yes or No o Rican, etc.)	14. Race - Ar White, etc	nerican Indian, Black,					
ter dea			1 X Yes 2 N ed If Yes, Give Year 1 Q 1 2 _	46 1	Yes 2	X No	specify:	,	Specify: V	<i>I</i> hite					
ours af atural	d by	15. Decedent's Education (Specify		1) 16a. Deced	ent's Usual	Occupatio	n (Give kind of		16b. Kind of 8usine						
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-003 d withi rgiene. ther th	Completed	9 17. Father's Name (First, Middle, La	st)		Pl			e (First Middle	PIUN Maiden Surname)	nbing					
215 be file ntal Hy rked o	Be	Arthur Z. Arno							Thomas						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	은	19a. Informant's Name/Relationship Robin Ingle/No							mber, City or Town, St						
and 2.		20a. Method of Disposition		Db. Place of Disp				Date	nd, MD 20						
nore ages 1 at of F		1 Burial 2 X Cremation 3	Removal from State	crematory or o	other place)	i	/21/10	Beltsvi						
altir mit. F partme portai		Donation 5 Other Special Signature of Funeral Service Lice	,												
		21. Signature of Funeral Service Licenses 22. Name and Address of Facility Raymond - Wood F . H . PO Box 430, Dunkirk, MD 20754 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart													
Physician /Medical		failure. List only one cause on	each line.		the mode	of dying, su	uch as cardiac	or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and Death					
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Head and neck Injuri Due to (or as a consequence							Death					
	<u>.</u>	Sequentially list conditions,	D												
	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated													
red Insit	Exal	events resulting in death) Last	Due to (or as a consequence	ce of):											
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	Medical	UNPENDED	dAMENDED	<u> </u>											
760, cate be exe physician i	/Med	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of p	regnancy					23d. Date of deliv	ery					
Box 6876 death certificate the attending phy of for use as the b	cian/I	past 12 months?	1 Live birth 4 Pregnant at time of		etal death Other (Spe	-	Ectopic pregn	ancy	Month	Day Year					
Boy e death the att	Physi	1 Yes 2 No 9 Unknow	9 Onknown												
, P.O.	by P	Part II. Other significant conditions			underlying	cause giv	en in Part I.			to the cause of death?					
ds, Faquires	ted	Hypertensive atheroscle	rotic cardiovascular di	sease				24a. Was		robably 4 Unknown autopsy findings available					
of Vital Records, g Physician: The law require wher this certificate has been si meral director, page 2 should b	Completed							autop perfo	prior prior death	o completion of cause of					
tal Rection: The certificate		25. Was case referred to medical				26 Place of	f Death (Check	1 Yes	2 No 1 🗸	Yes 2 No					
Vita hysician this cer	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	✓ ER/Outpatie			thor -		Residence 6 Ot	ner.					
	n: T	27. Manner of Death	28a. Date of Injury Oct 17, 2010	28b. Time of 1623 hrs	Injury	28c. Injury			how injury occurred tractor crashed	n his hackvard					
Division ospital or Attendi hours after death.	Certification	2 Accident 5 Pending Investiga	ation		(s 2 🗸 No								
Divi	ertifi	Suicide 6 Could no determin			eet, ractory	, orrice buil	iding, etc.	or Town, S		Rural Route Number, City d. MD					
e Hospi n 24 hou e Funer letely fil		29a. Certifier 1 Certifying Physi	cian: To the best of my know	ledge, death occ				due to the caus	e(s) and manner as s	ated.					
To the within 2 To the complet	Medical		er: On the basis of examinatio and manner stated.	n and/or investig				at the time, date							
	Σ	29b. Signature and title of certifier	, /		290	c. License r O.C.M.			29d. Date signed (iii October 18, 20						
		30. Name and address of person who	o completed cause of death ()	tem 23a)		O. O.IVI.			OCIODEI 10, 20						
dru 4+1		Zabiullah Ali, M.D. Ass	sistant Medical Examin		nn Stree	t, Baltim	nore, MD 21	1201							
St Regist	ate	31. Date filed (Month, Day Year)	2010 32. Registrar's Sign	nature 6. A	arks	0		<u> </u>							
17-74 (2)	48.11	- W 1 tul "		1											

10-08295 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jonathan Llyod Anderson State of Maryland / Department of Health and Mental Hygiene 34976 0 1 0 Certificate of Death 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Month Day October 30, 2010 **Medical Examiner** 1511 hrs Jonathan Lloyd Anderson 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 223 Belle Hill Road Cecif 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director 1 X M 2 F 23 Country) 220-21-1075 02/20/1987 Usual Residence of Decedent any 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 X No Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Marvland Ceci1 E1kton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 223 Belle Hill Road United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? 1 X Never Married 2 Married White, etc. 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: White \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Sales Associate Retail 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Stephen E. Anderson, Sr. Stephenie Embrich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephenie Combs/Mother 223 Belle Hill Road, Elkton, MD 21921 20a. Method of Disposition Department (**Physician** /Medical Examiner Examiner Physician/Medical Completed by

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi Division of Vital Records, P.O. Box 68760,

Certification: To

Medical

State

Registrar

mente

Margarita Korell MD.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

1 X Burial 2 Cremation 3	Removal from State C . cremator	y or other place) No Manor 5	ovember 200.200	ation - City of Town, State
4 Donation 5 Other Specify:	Memori:	Manor al Park	, 2010 E	1kton, MD
21. Signature of Funeral Service Licens	ee	22. Name and Address of Facility	licks Home for	Funerals, P.A.
1	H: A)	103 W. Stockto		
23a. Part I. Enter the disease, or compli	cations that caused the death. Do not			
failure. List only one cause on each	th line.	onto the mode of dying, soon as our die	ac or respiratory arrest, shock,	Between Onset and
	Oxycodone intoxica	ation		Death
or condition resulting in death)	Due to (or as a consequence of):			
Sequentially list conditions, b				
if any, leading to immediate	Due to (or as a consequence of):			
cause. Enter Underlying Cause (Disease or injury that initiated				
events resulting in death) Last	Due to (or as a consequence of):			
d				
X UNPENDED	AMENDED.	5 257 010 16	1/10/10 mm	i
IF FEMALE:		a-f,per ME g910 12		
23b. Was decedent pregnant in the	23c. If yes, outcome of pregnancy	Testal de esta 3 Testania e en		ate of delivery
past 12 months?	December of death	Fetal death 3 Ectopic pre	gnancy	onth Day Year
1 Yes 2 No 9 Unknown	9 Unknown	Other (Specify)		
Part II. Other significant conditions		a the condent in a course since in Deat I	22a Did tabasas usa	and the same of death?
Cocaine use	contributing to death but not resulting i	n the underlying cause given in Part I.		contribute to the cause of death?
- Goedine doc			1Yes 2 ✔N	o 3 Probably 4 Unknown
				24b. Were autopsy findings available
			autopsy performed?	prior to completion of cause of death?
			1 ✓ Yes 2 No	1 ✓ Yes 2 No
25. Was case referred to medical		26.Place of Death (Che	eck only one)	
examiner? 1 ✓ Yes 2 No	ospital: 1 Inpatient 2 ER/Out	patient 3 DOA Other Nu	rsing Home 5 Residence	6 Other: Scene
27. Manner of Death	28a. Date of Injury 28b. Tir	ne of Injury 28c. Injury at Work?	28d. Describe how injury	occurred
1 Natural 5 Pending	(Month, Day, Year)	1 Yes 2 No	unk	
2 Accident Investigation		3.00 pm — —		
3 Suicide 6 X Could not b	e 1 - 1 - 1 - 1	n, street, factory, office building, etc.	28f. Location (Street and	Number of Rural Route Number, City Belle Hill Rd
4 Homicide determined	(Specify) hotel re	O O III	Elkton, MD	
29a. Certifier (Check only 1 Certifying Physicia	in: To the best of my knowledge, death	occurred at the time, date and place, a	and due to the cause(s) and m	anner as stated.
one) 2 Medical Examiner:	On the basis of examination and/or invaled manner stated.			
29b. Signature and title of certifier	and memor stated.	29c. License number	29d. Date	e signed (Month, Day, Year)

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

October 31, 2010

Ohio

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar #18 Certificate of Death TCHD. 10/14/2010. TLS 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4:30 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Health ente Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Months Hours Min Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a.1 ober any injury or other traumatic avoirs. 10c. City, Town or Location Caroline 10d. Inside City Limits Completed by Funeral Director 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 216 a USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Black Specify: 3 ¥ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) မှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number (daughter ueline Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Fignature of Juneral Service Licens 22 Name and Address aston 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Agset and Death Physician/ TAGE END disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIABETES, ATHEROSCLEROTIC CARDIO 1 Yes 2 No 3 Probably 4 Unknown DISEASY 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 Yes 2 No Accident Investigation ☐ Accident☐ Suicide☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) TENDING of death (Item 23a) (Type, Print) Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Plea	se Type or Pri					-		_	Э.	
		For State Registrar		State of M	laryland		artment of I rtificate of L			giene Reg. No	2010	34978	
Physicia	ın/	1. Decedent's Name	e (First, Middle,	Last)					2. Date of De Month	ath		3. Time of Death	
Medic Examin	al			FLAND BENN give street and number)	INGTO	N	Ab City Town o	r Location of Death	OCTOBEF		Year 19 201		
Examili	ei			MEMORIAL H	OSPTT.	ΔТ.	FREDE			40	FREDEF		
Funeral		5. Social Security N	umber		je (In yrs. las	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	th	9. F	Birthplace (State or Foreign	
Director		215-16-68 Usual Residence of			87	Yrs.			May 5,	″192	3 N	laryland	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	tor	10a. State	10b. County	-	10c. City,	Town or Lo	cation					10d. Inside City Limits	
e Man r 28a- notifie	Funeral Director	Maryland 10e. Street and Nun	Frede	rick		Fred	erick	 -				1 🗌 Yes 2 🔀 No	
vith th	rall			ad, Apt. 32	1		10f. Zip Code 21702			_	tizen of What (ited St	-	
eath v tems er mu	Fune	11. Marital Status	110M VO	12. Was Decedent	Ever in U.S.		Was Decedent of H	ispanic Origin? (Sp	pecify Yes or No-		nerican Indian,		
after d ", or i	by	1 Never Marri		100 2	No		f Yes, specify Cuba 1 ☐ Yes 2 🎦 No		o Rican, etc.)		Black, Wh	,	
atural	eted	3 Widowed	4 LJ Divorced 15. Decedent	Year or Dates.	WWII		dent's Usual Occup			100 10			
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permi Depar Impor any ir		21. Signature of Flui	noral Service Li	ensee		16	2. Name and Address	ss of Facility St umtown Pi	auffer I ike Fre	Fune: ederi	ral Hom ick. Ma	nes, P.A. ryland 21702	
		23a. Part 1. Enter t	he disease, or o	omplications that cause	d the death.	Do not ente	er the mode of dyin	g, such as cardiac	or respiratory an	rest,		Approximate Interval Between	
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requires that the de been signed by the should be detached				s contributing to death b	out not resu	lting in the u	inderlying cause giv	ven in Part I.	23e. Did to	phacco u	use contribute	to the cause of death?	
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The law ate has page 2 s	Som								autor perfo 1 🔲 Yes	rmed?	death	completion of cause of	
iician: The certificate rector, pag	Be	25. Was case referre examiner?	4	Hospital:				ace of Death (Chec	ck only one)				
Phys r this c eral dir	e: To	1 Yes 2 27. Manner of Death	No n	1 Inpati 28a. Date of inju		R/Outpatier 28b. Time of	other DOA Other	4 LJ Nursing H	ome 5 Resid			ecify)	
Attending Physician: er death. ector: After this certific by the funeral director,	icat	1 Natural 2 Accident	5 Pending	(Month, Da	y, Year)	injury	work		Zod. Describe ii	iow injury	y occurred		
or Atte	Certificate	3 ☐ Suicide 4 ☐ Homicide	6 ∐ Could n determir		ury - At hom c. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (S City or Tow			ural Route Number,	
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To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After the completed filled in by the funeral	Med	(Check 2 only one) 3		aminer: On the basis of e Nurse Practioner: To the	xamination:	and/or invest	tigation, in my opinic	n. death occurred a	at the time, date a	and place	and due to the	e cause(s) and manner stated.	
To with		29b. Signature and t	title of certifier				29c. License	number		29d. Dat	te signed (Mor		
				ho completed cause of d	leath (Item 2	23a) (Type, P	Print) FREGE		1 /2 1 2		(/		
SHIVA		31. Date filed (Month		WY H 0 19	6 TJ	1/20	E, TREDE	uct.Ml	11/02	•			
Stat Registra	-	S. Date ned (World	OCT 2	32. Hegistra	ar's Signatu	A.	parke						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October Mary E. Bowers 2010 5:05p Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Golden Living Center Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Dec. 9, 1920 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Days Hours Country) Maryland Yrs Director 214-16-1471 89 Dec. Usual Residence of Decedent shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10h County items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 K No Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13317 Copper Ridge Road 20874 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ral", or iten Examiner 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Secretary United Health Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Clinton Baker Blanche Conrad 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martin C. Bowers / Son 13317 Copper Ridge Road, Germantown, Maryland 20874 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Loudon Park Cemetery | 10/26/2010 | Baltimore, Maryland 21. Signature of Juneral Serv 22. Name and Address of Facility Stauffer Funeral 1621 Opossumtown 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Anteny Physician/ ATHERO ononmy solemosis Medical resulting in death) Due to (or as a consequence of): Examiner ON YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to for as a consequence on attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Year 5 Other (specify) Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 No this certificate 1 🗌 Yes 2 No completed filled in by the funeral director, B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 Other: No 잍 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of s after death. I Director: After t 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Acciden Hospital or Attending 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cartifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signatur and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 10-22-20 47951 Name and address of person who completed cause of death (Item 23a) (Type, Print) Toll House Ave Frederick Mo A. KAZMI જાપ 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34980 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Charles Sheldon Bresler 2010 2:41 P M October Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 0 1/11 71 927 1 X M 2 D F Months Days Hours Pennsylvania Director 578-30-9173 83 Usual Residence of Decedent or 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Rockville 1 K Yes 2 No 10e Street and Number 10f. Zip Code ŏ 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral with 10401 Grosvenor Place #1703 20852 United States hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

X Yes 2 No World Black. White, etc 1 Never Married 2 K Married δ 3altimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates. War II 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed perfit. Page 1 and 2 should be filed within 72 hou. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical lonce. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Real Estate Real Estate Developer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Samuel Bresler Katharine Manoff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fleur Bresler / Wife 10401 Grosvenor P1. #1703 Rockville, MD 20852 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Garden of 10/25/2010 Remembrance Cemetery Clarksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service Licensee 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final as to rosclerotic Physician/ ras drovaverta disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Samuration list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be exemination 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician a coppleted filled in Dy the funeral director, page 2 should Le detacted for use as the terminal-the Physician/Medical Division of Vital Records, P.O. Box 68760 0 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 1 ☐ Yes ∠ ∟ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Tunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe Yes 2 X No 2 🗓 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \sum Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) pleted filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifiei 1- Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

10-07875 Unk Unk Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2010 3498 State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar	Certificate	of Death	Reg. No.										
Physician/ Medical Examine		ast) enson		Date of Death Month Day Yea October 13, 2010	3. Time of Death 1420 hrs									
	4a. Facility Name (if not institution, Randolph Road @ Neve		4b. City, Town, or Location of Dea Rockville	4c. County Montgor										
Funeral Director	219-94-9702	Sex 7. Age (In yrs. last birthday 45		1rs. 8. Date of Birth (MM/DD/YYYY) 1in. 05/12/1965	9. Birthplace (State or Foreign Country OTOCCO									
ku a	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Limits									
and show a	MD Montgom	ery Rockvi	.11e		1 X Yes 2 No									
h the Maryland 3a or 28a-f show any otified at once. I Director		Pike #1412	10f. Zip Code 20852	10g. Citizen of Wi United	nat Country? States									
Jimore, MD 21215-0036 Jimore, MD 21215-0036 Jimore of Health and Mental Hygiene. Tent: If item 27 is marked other than "natural", or items 23s or 28s-f sho or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 XNever Married 2 Marri 3 Widowed 4 Divorce	ed Armed Forces?	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer Yes 2 X No specify:		- American Indian, Black, e, etc. White									
ours aft	15 Decedent's Education (Cassific	only highest grade completed) 16a. Dece	edent's Usual Occupation (Give kind o	f work done 16b. Kind of Bu	siness/Industry									
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	ng most of working life. DO NOT use n Retail Sales	Cloth	ing									
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica FO Be Comple		st)		ne (First, Middle, Maiden Surname)									
2121: nould be fil d Mental Is s marked tic event, To Be	Charles Benson 19a. Informant's Name/Relationship	(Type, Print) 19b. Ma	Esthe	er Dahan rRural Route Number, City or Tow	n, State, Zip Code)									
MD id 2 shoulth and in 27 is animati	Charles Benson-		l Rockville Pike											
Baltimore, MD 21215-005 Bealtimore, MD 21215-005 permit. Pages I and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other ti injury or other traumatic event, the Med	20a. Method of Disposition 1 X Burial 2 Cremation 4 Donation 5 Other Speci	Removal from State Mt Leban		/20/10 Adelphi										
Baltime permit. Pag Department Important: injury or ot	21. Signature of Funeral Service Lic	M01163	2. Name and Address of Facility Lidward Sage Fune:	ralıDirection In Ville Pike Rockv	111e MD 20852									
Physician /Medical	23a. Part . Enter the disease, or confailure. List only one cause on	Between Onset and												
Examiner	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):			Death									
5	Sequentially list conditions, b													
ted Insit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	c. Due to (or as a consequence of):												
recuted n and rtransit	events resulting in death) Last	d.												
760, cate be execui physician and he burial - tra	UNPENDED	AMENDED												
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial. Transiedical Certification: To Be Completed by Physician/Medical E.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregion	23d. Date of Month	delivery Day Year									
O. Bo t the deat by the at sched for Phys	Part II. Other significant condition	wn 9 Unknown s contributing to death but not resulting in the	he underlying cause given in Part I	23e. Did tobacco use contri	bute to the cause of death?									
, P.O. res that th signed by be detach				1 Yes 2 ✔ No 3										
Records, The law requires ficate has been sig page 2 should be Completed	De la proper de la company de													
tal Rec cian: The la certificate h ector, page 2		T		1 Yes 2 No 1	eath? Yes 2 No									
Vital hysician this cert I directo	25. Was case referred to medical examiner? 1 V Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpat	26.Place of Death (Check ient 3 DOA Other Nurs	k only one) ing Home 5 Residence 6	Other: Scene									
Division of Vital Records, is or Attending Physician: The law requirers after death. The Director: After this certificate has been simed in by the funeral director, page 2 should bertification: To Be Completed	27. Manner of Death 1 Natural 5 Pending			28d. Describe how injury occurre Subject jumped in front of										
Division ospital or Attending hours after death. Increal Director: After filled in by the fune Gertification:	3 Suicide 6 Could no determin	ot be 28e. Place of Injury - At home, farm, s	street, factory, office building, etc.	28f. Location (Street and Number or Town, State) Randolph Road @ Nevel Str										
To the Hospital within 24 hours To the Funeral completely filled		ician: To the best of my knowledge, death or er:On the basis of examination and/or invest												
Σ	29b. Signature and title of certifier	and manner stated	29c. License number		ed (Month, Day, Year)									
3	famel Touth	all, MD	O.C.M.E.	October 14	, 2010									
	30. Name and address of person wh Pamela E. Southall, MD	o completed cause of death (Item 23a) Assistant Medical Examiner	111 Penn Street, Baltimore,	MD 21201										
State Registrar		32 Registrar's Signature	alle											

State of Maryland / Department of Health and Mental Hygiene For State Registrar 34982 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 23. Anne 2010 Bossler 12:30 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 20114 Clay Road Hagerstown Washington County 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🗓 F (Month, Day, Country) Mary Land 220-58-2900 Director 60 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27:3 marked of other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d, Inside City Limits Maryland Washington Co. Hagerstown 1 Tes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20114 Clay Road U.S.A. 2**17**42 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2XXNo
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Payroll Clerk 12 Power Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္ပ Joseph Earl Bitner Hazel Eiler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20114 Clay Road, Hagerstown, Maryland Bernard L. Bossler / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Rest Haven Cemetery Oct. 27,2010 Hagerstown, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 331 Fastern Blvd. N., Hagerstown, MD 21742 untos at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest deach line. 23a. Part 1. Enter the disease, or complications to shock, or heart failure. List only one cause of Immediate Cause (Final disease or condition and Death Myoman Physician/ Cel. Medical resulting in death) (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the attending physician and thed for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?
1 Yes 2 No
9 Unknown Day Year 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident injury work? 5 Pending 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on Signat 0 30. Name and addr WH-L M 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 34983 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Month William Henry Barber, Jr. 35 PM 2010 Medical CTOBER 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Washington County Hospital Washington County Hagerstown Social Security Number 6. Sex 1 X M 2 □ If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign Country) West Virginia 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours Dec. 14 Months Days Min. 214-46-5194 Director 63 Usual Residence of Decedent or 28a-f shov 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director Maryland | Washington County Hagerstown 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23aFuneral 14166 Shelby Circle 21740 U.S.A. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. the Medical Examiner 14. Race - American Indian, Was Decedent Ever III C. Armed Forces? 1 X Yes 2 No 7-If Yes, Give 1967-Year or Dates. 1969 Black, White, etc. ò δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Sales Safety Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H ၉ William H. Barber, Sr. Jane Elliott Barber permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian T. Barber-son 63 Tanger Rd. Boiling Springs, PA 17007 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 \square Burial 2 $\! \stackrel{igstyle imes}{igstyle imes}$ Cremation 3 \square Removal from State SmithsburgCrematory 10-26-2010 4 ☐ Donation 5 ☐ Other (Specify) |Smithsburg, Maryland . Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 23a. Part 1. Enter the disea e, or or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1331 Eastern Blvd. North Hagerstown, MD 21742 Immediate Cause (Final Onset and Death Physician/ nd-Stage ives disease due to alcohol disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year signed by the a d be detached f 1 Yes 2 g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy death? Hospital or Attending Physician: The 24 hours after death.
 Funeral Director: After this certificate It 2 1 2 🗌 No Yes 25. Was case referred to medica **Division of Vital** funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) ည 1 ☐ Yes 2 ☐ No 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending 1 Yes 2 No ☐ Accident Investigation completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 only one) 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year)
October 26th, 2010 162588

₩9+1 SI

State Registrar JUDITH MEADUM, FLD 251
31. Date filed (Month, Day, Year) 6 2000
32. Rigistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ature

nhetam St

251 5 4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For Amend Item 26 State of Maryla State Registrar WCHD/SH 10/26/10 per Dr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 21, 2010 James Franklin Brooks 9:20 A.M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Washington Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** (Month, Day, ep 10, 1**X**] M 2 □ F Hours Country)
Maryland Director 212-20-2147 Sep Ĩ924 Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No Rohrersville Maryland Washington 10e. Street and Numbe 10f. Zip Code ō 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with Inportant of Health and Mental Hygiene. Begarment of Health and Mental Hygiene and the file of the marked other than "matural", or items 23a any injury or other traumatic event the Mariana. Funeral U.S.A. 21779 4303 Main Street Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 X Yes 2 \(\sigma\) No 1943-Black, White, etc. ρ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: Completed 3 Widowed 4 Divorced 1945 White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Grocery Store 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Titus Brooks Anna Mary James Ε. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sally F. Brooks / Wife 4303 Main Street Rohrersville, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10-25-2010 | Rohrersville, Maryland 21. Signature of Tuneral Service Licens 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA 7606 Old National Pike Boonsboro, MD 21713 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Disensa Immediate Cause (Final Onset and Death ATheroscienoTC (Androvagolan Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions. Due to or as a consequence of cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed CANCER 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Recidence 6 Other (Specify) 1 🔲 Yes 2 No ဂ္ 1 ☐ Inpatient 2 🔀 ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No hin 24 hours arer decth. the Funeral Director: Af mpleted filled by the fu 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined cal 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0035152 10.2210 MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21788 OH 5+1 100 KraNTZ MO CENTA 5

DHMH 17 Rev 7/2009

State

Registrar

32

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ochonth 22, Day 2010 Year Evelyn Arleen Barron 2:45A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Williamsport Retirement Williamsport Washington Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day Yea Dec 3 1 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1919 Country) Leetown **Funeral** 1 M 2XX Hours 233-40-9366 Director Yrs. 90 Usual Residence of Decedent 28a-f shov 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Washington Williamsport 1 ¥ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 40 E. Village Lane 21795 **IISA** 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3XXWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n any injury or other traumatic event, the Medi (Specify only highest grade completed) ntary/Seconday (0-12) College (1-4 or 5+) homemaker domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Barney Annie Everett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Adams/daughter 7312 Maple Ave. Takoma Park, MD 20912 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rosedale Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 10/24/10 Martinsburg, WV 4 Donation 5 Other (Specify) Signature of Funeral Solvice Licensee Home VV 25404 Rosedale Funeral 22. Name and Address of Facility 917 Cemetery Rd. Martinsburg, Enter the disease, or comeli that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate se on each line. nterval Between Immediate Cause Imnal le Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner WHUAN Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): vsician and death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the a To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached. P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 000 Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work Accident 1 Yes 2 🗌 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hagerstown 32. Pegistrar's Signature State

DHMH 17 Rev 7/2009

Registrar

10-08172 Helen Broomfield Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

relett broottille		1- For State Registrar	Certificate of	r Health and Mental f Death		2 U 1 U	34986							
Physic Medical Exam		Decedent's Name (First, Middle,Last)	iold		2. Date of Deat Month October 26	h	3. Time of Death 1515 hrs							
Weulcai Exam	IIIIĢi	Helen Tracy Broomf 4a. Facility Name (if not institution, give street and nur		4b. City, Town, or Location of De		4c. County of Death								
		Harbor Hospital Center		Baltimore										
Funeral Director		578-96-5881 1_M 2XF	7. Age (In yrs. last birthday) 43 Yrs		8. Date of Birt 104/26	/1967 Soreig								
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Locati	ion			10d. Inside City Limits							
* .	Ļ	MD		Baltimore			1 X Yes 2 No							
Maryland 28a-f show d at once.	Director	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Cour	ntry?							
th the 23a or notifie	Ö	2708 Hollins Ferry R		21230		USA								
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int. If item 27 is marked other than "natural", or items 23a or 28a-f sho mrit. If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	_	11. Marital Status 1 Never Married 2 Married 1 Yes 3 Widowed 4 X Divorced If Yes, Give Year	rces? If Y	is Decedent of Hispanic Origin? (es, specify Cuban, Mexican, Pue Yes $2[\overline{X}]$ No specify:		White, etc.	can Indian, Black, iite							
ours afi atural' aming	d by	or Dates: 15. Decedent's Education (Specify only highest grade	completed) 16a. Deceden	t's Usual Occupation (Give kind o		16b. Kind of Business/li								
215-0036 be filed within 72 hours after and Hygiene. The Other than "natural", the Other than "natural", the Medical Examiner.	Completed	Elementary/Secondary (0-12) College (1-	4 or 5+)	ost of working life. DO NOT use r	etired)									
-000 d withing giene.	mox	17. Father's Name (First, Middle, Last)		Homemaker 18.Mother's Na	me (First, Middle, M	Own Hom	ie .							
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	Claude Allen Baile	У	Dorc	thy Emi	ly Crosby								
D 21 Should and Me is ma	욘	19a. Informant's Name/Relationship (Type, Print) Katie Broomfield/Dau	thter 6535	Address (Street and Number of Bayside	r Rural Route Numl Road	ber, City or Town, State,	Zip Code)							
and 2. Sealth 2 tem 27 tem 27		20a. Method of Disposition	20b. Place of Disposi	apeake Beach, ition (Name of cemetery,	MD 207 Date	32 20c. Location - City or								
nore ages 1 ant of F other		1 X Burial 2 Cremation 3 Removal from	m State crematory or oth	erplace) Coln Cem. 11		Brentwoo	od.MD							
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical	1	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	-777	ame and Address of Facility R										
	1	PO Box 430, Dunkirk, MD 2075 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart												
Physician //Medical		failure. List only one cause on each line.	used the death. Do not enter th ting on food	ne mode of dying, such as cardiad	or respiratory arre	st, snock, or heart	Approximate Interval Between Onset and Death							
xaminer		immediate Cause (Final disease a.	consequence of):											
	<u>_</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):												
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated												
ited d ansit	Exa	events resulting in death) Last Due to (or as a d	consequence of):											
OX 68760, ant certificate be executed attending physician and or use as the burial - transit	Medical	37	.PTT.27.28a-f	per ME g909 11	/18/10 T	r								
760, icate be physical the buri	/Mec	IF FEMALE: 23c. If yes, or	utcome of pregnancy			23d. Date of delivery								
Box 687 e death certifice the attending p	Physician/I	past 12 months?	at at time of death	al death 3Ectopic preg ner (Specify)	nancy	Month D	ay Year							
BO) ne deatl the att	hysi	1 Yes 2 No 9 V Unknown 9 Unknow	vn											
Records, P.O. Box 68760, The law requires that the death certificate be executed toate has been signed by the attending physician and page 2 should be detached for use as the burial - transi	by	Part II. Other significant conditions contributing to a Chronic narcotism	leath but not resulting in the u	nderlying cause given in Part I.		acco use contribute to to 2 No 3 Proba								
rds, require been si	Completed				24a. Was ar		opsy findings available							
of Vital Records, ng Physician: The law requir After this certificate has been s neral director, page 2 should 8	dwo				autops perform 1 Yes 2	ned? death?	ompletion of cause of							
al Re ian: Th certificat	BeC	25. Was case referred to medical examiner?		26.Place of Death (Chec										
F Vit Physic or this c	To E	1 ✓ Yes 2 No	patient 2 ER/Outpatient			esidence 6 Other.								
ion of tending Pheath.	ion:	1 Natural 5 Pending 10.404	Day,Year)	1 You 2 X No	1	ow injury occurred choked on	food							
	Certification:	2 X Accident Investigation 10/24	/10 6:15 pt of Injury - At home, farm, street	11-	28f. Location (St	reet and Number or Rur	al Route Number City Ro							
Divis pital or At ours after d teral Birect filled in by	Certi	4 Homicide determined (Specify)	house		or Town, Sta Baltimon	re, MD	ins relly ac							
To the Hos within 24 h To the Fun completely		29a. Certifier 1 ☐ Certifying Physician: To the best (Check only one) 2 ✓ Medical Examiner: On the basis of												
To tl To tl Com	Medical	29b. Signature and title of certifier		29c. License number		29d. Date signed (Mont								
		aus 2		O.C.M.E.		October 28, 2010	, 20,, . 501/							
		30. Name and address of person who completed cause	of death (Item 23a)											
				treet, Baltimore, MD 2120)1									
S	tate	31. Date filed (Month, Day, Year) 1 2010 32. R/g	istrar's Signature	. d. l.		• •								

OCME

Registrar DHMH 17 Rev 7/2009

State

32. Registrar's Signature

814 Toll House Ave., Frederick, MD 21701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sibte A. Kazmi, M.D.

31. Date filed (Month, Da

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCMOBER 2010 5:13A HARRY ERNEST BAKER JR Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 🛛 M 2 🗆 F Months Days Hours Min Oct. 24 89 1920 Director 515-07-8407 Kansas Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Frederick Frederick Md. 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21702 990 Waterford Drive, #304 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc þ 1 Never Married 2 Married White 1 ☐ Yes 2 🗷 No Specify: WWII Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Government Elementary/Seconday (0-12) College (1-4 or 5+) Printing Office Printer 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Mildred Lyster Harry E. Baker, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leesburg, Va. Danworth A. Baker / Son 201 Ayrlee Ave., N.W., 20176 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 10/21/10 Alexandria, Metropolitan Crem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Facility
Muriel H. Barber Funeral Home
P. O. Box 5038, Laytonsville 20882 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sub dural Physician/ disease or condition resulting in death) Dery Medical Due to (or as a consequence of): 20 Examiner Sequentially list conditions, Examiner cause (Disease or linjury that initiated events Due to for as a consequence of: the attending physician and hed for use as the burial-transit CRRBOUDE resulting in death) Last Due to (or as a consequence of) Physician/Medical b Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
b Funeral Director: After this certificate has been signed by the attending physicial IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year cate has been signed by the a page 2 should be detached Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performe 2 🗆 No Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending fell while walking 2 Accident 10/15/2010 1 🗌 Yes 2 🔀 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 990 Worter Ford Dr. Frederick 1 MD 4 Homicide determined at home 29a, Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 7/2009

THIVA

32. Regist ar's Signature

Michael A.

Tolino,M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

OCT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Morris Baker Month 2010 October 6:30 A. Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick 14820 Sabillasville Road Thurmont Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8 Date of Birth **Funeral** Country) Maryland 220-46-8189 1x x M 2 □ F Months Days Hours Min January 66 Director Usual Residence of Decedent show 10a State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director Maryland Frederick 28a-f Thurmont 1 Yes ZXX No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? must be 23aFuneral 13820 Sabillasville Road 21788 USA 12 Was Decedent Ever in LLS 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. the Medical Examiner Black, White, etc ò ģ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: white Specify "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Master Painter other t Painting Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other frameway. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Morris Franklin Baker Helen Getz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Baker - wife 14820 Sabillasville Road, Thurmont, Maryland 21788 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Toremation 3 ☐ Removal from State Stauffer Crematory 10-20-2010 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 22. Name and Address of Facility Signature of Funeral Service Licensee Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. mmediate Cause (Final Physician/ disease or condition year Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate Examine Due to or as a consequence of cause. Enter Underlying Cause (Disease or linjury that initiated events attending physician and for use as the burial-transil Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death signed by the a d be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 📝 No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Records, P.O. has this certificate Division of Vital To the Hospital or Attending thin 24 hours after death.

the Funeral Director: After properties of the function of the func within 24 hours a

Box 68760

Baltimore, Maryland 21215-0036

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) is human

32. Regist

ar's Signature

ALCOHA.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar	State of	of Mar	ylanc		rtment o		ealth and I e <i>ath</i>		21	10	34	990	
			Decedent's Name (First, Middle)	e, Last)				imouto (<u> </u>	-	2. Date of De				e of Death	
Physi Me	ician. edica		Sandra L. Boy	er							Octobe:	r 14,	2010	22 5	5 hrs™	
	mine		4a. Facility Name (if not institution 11920 Main S	-	n <i>ber)</i>					ocation of Death			unty of Dea ederi			
Fune Direct		- 1	5. Social Security Number 215-32-6089	6. Sex 1 \(\text{M} \) 2\(\frac{1}{2} \) F	7. Age (// 7.		t birthday) Yrs.		Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da June 4		9. Bii Cc Vir	rthplace (State ountry)	te or Foreign	
T M		_ h	Usual Residence of Decedent 10a, State 10b. County			- 0"						,				
laryland 3a-f sh ified a		J I	Maryland Frede				Town or Loc rtytov								e City Limits Yes 2 🗌 No	
with the M 23a or 28 ust be not	100	runeral Dir	10e. Street and Number 11920 Main St	reet				10f. Zip Co	ode 762			10g. Citizen of What Country?				
DAIKIMOFE, IMARYIGANG Z1Z13-UUJO permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	7	2	11. Marital Status 1 Never Married 2 Mar	If You Giv	orces? 2 🔼 No /e		If		Cuban	Mexican, Puerto	Specify Yes or No- into Rican, etc.) 14. Race - / Black, V Specify:			erican Indian te, etc. white	,	
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Te, Maryi and 2 should I Health and Me tem 27 is marl			19a. Informant's Name/Relations Maurice Boyer	hip (Type, Print) – husband						d Number or Rui					762	
IOFE, ge 1 and nt of Hea ilfitern or othe			20a. Method of Disposition 1 🔀 Burial 2 🗌 Cremation	3 Removal from	State	cer	netery, crem	sition (Name o atory or othe			Date		-	r Town, State		
Daitimor Demit. Page 1 Department of mportant: If it any injury or or		1	4 ☐ Donation 5 ☐ Other (\$ 21. Sig - ture of Funeral Service)			Uni	on Cha	pe1 Name and A	ddmoo	_	8-2010	Liber			cyland	
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Physicia Medic Examin	cal	1	23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	only one cause on ea	cau d thach ine.	ter	istil	the mode of		such as cardiac	or respiratory and	rest,			mate Between nd Death	
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icate be executed physician and sthe burial-transit	dical Evaminar	Lyalli	Cause. Enter Underlying Cause (Disease or finjury that initiated events resulting in death) Last	c. Due to	(or as a c	onseque	nce of):						(6)			
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es that the signed by	hy Dh	2	Part II. Other significant condition	ns contributing to d	leath but	not resul	ting in the ur	nderlying caus	se give	n in Part I.	23e. Did to	obacco use co	,	o the cause o		
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ician sician certifi rector	8	۱ د	25. Was case referred to medical examiner? 1 \(\sum \) Yes \(2 \sum \) No	Hospital:		-			Other:	e of Death (Chec						
OT V g Phys er this ieral di	٩		27. Manner of Death	28a. Date	of injury	2	R/Outpatient 8b. Time of	28c.	Injury a	4 ☐ Nursing H	ome 5 Resid			cify)		
VISION OF The Attending Plant death. Virector; After the by the funera			1 Natural 5 Pendir 2 Accident Investir 3 Suicide 6 Could	gation	th, Day, Y	ear)	injury		work?	es 2 🗆 No						
DIVISI Ital or Att Irs after d al Direct	ol Cortificate.		4 Homicide determ	inod 28e. Place	of Injury ng, etc. (5	- At hom Specify)	e, farm, stre	et, factory, of	fice		28f. Location (S City or Tow		nber or Ru	ural Route Nu	mber,	
he Hospi in 24 hou he Funer	Modical	NICOLO.	(Check 2 Medical E	Physician: To the base examiner: On the base Nurse Practioner:	sis of exan	nination a	and/or investi	gation, in my	opinion	death occurred a	at the time, date a	nd place, and	due to the	cause(s) and	manner stated.	
Veith Con Con Con Con Con Con Con Con Con Con			29b. Signature and title of certifier					29c. Lic	-	6516		29d. Date sig		. 97	2010	
		-	30. Name and address of person	who completed caus	e of deat	h (Item 2	3a) (Type, Pr								2010	
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Regi.	State	•	31. Date filed (Month, Day, Year)	0 0 201 0 S2. R	legist ar's	Signatur	e A	back	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Daγ **Physician** DONALD E. BATES 10/18/2010 7:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2624 TODDVILLE BACK ST. **TODDVILLE** DORCHESTER 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days Months Min. 1 M M 2 □ F Hours Yrs Director 189-14-1872 84 3/17/1926 PENNSYLVANIA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Director Examiner night be notified 1 ☐ Yes 2X No MARYLAND DORCHESTER **TODDVILLE** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with ō Items 23a 2624 TODDVILLE BACK ST. 21672 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, hours after 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐Yes 2X No Specify. 3X Widowed 4 ☐ Divorced WHITE 1943 - 1945 event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 I Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "nat any finJury or other traumatic event, In "Modie (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TILE MECHANIC 12 MANUFACTURING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **AUSTIN BATES** 2 MARION HOLDEN 19a. Informant's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DONNA REUSING / DAUGHTER 31101 NATIONAL PIKE, LITTLE ORLEANS, MD 21766 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2X Cremation 3X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON NATIONAL CEMETERY 12/1/2010 ARLINGTON, VA 21. Signature of Funeral Se 22. Name and Address of Facility CURRAN-BROMWELL FUNERAL HOME, P.A., 308 HIGH ST. CAMBRIDGE, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** CANCER PANCREATIC MONTHS resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underl, in Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the burial-tran and Due to (or as a consequence of) physician Physician/Medical use as attending IF FEMALE 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Vear 4 Pregnant at time of death 5 Other (specify) the ☐Yes 2☐No detached 9 Unknown 9 Unknown as been signed by 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page 1 ☐ Yes 2 [1 ☐Yes 2 ☐ No or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 5 Residence 6 □ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No i Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a To the Funeral D Hospitai Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signatur and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 18 2010

Division of Vital Records, P.O. Box 68760

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

8221 Teal Drive, Easton, MD

21601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

David H. Smith, M.D.

31. Date filed (Month, Day, Year)

10-08269 George Doss Baker

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2010 21.002

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30. Name and address of person who completed cause of death (Item 23a) Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	E 3 E 8	ž			29c. Licen	se number		29d. Date signed	(Month, Day, Year)						
Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		- 1			0.0	.M.E.		October 30, 2	2010						
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	OCME	ŀ	30. Name and address of person who completed cause of de	ath (Item 23a)											
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		[•	al Examiner 11	1 Penn Stree	t, Baltimore, M	ID 21201								
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 7:45 P Physician/ OMerbber 2019 William Henry Biddinger Jr Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Frederick Memorial Hospital 6. Sex 1 X M 2 □ F If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 0772871931 215-26-1753 Maryland Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director MD Frederick 1 Yes 2 No Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 10626 Powell Road 21788 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Was Decedent 2√0. Armed Forces? 1 ☐ Yes 2 🗓 No Black, White, etc. Š 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: White Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Machinist Trucking Company 12 should be filed with and Mental Hygie 27 is marked other r traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Henry Biddinger, Sr. permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Clara Marie Kolb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruby Biddinger / wife 10626 Powell Road, Thurmont, MD 21788 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Mem. Gardens 11/03/2010 Frederick, MD 22. Name and Address of Facility Ceeney & Basford Funeral Home 21. Signature of Funeral Service Licenses Jamelle Kri 106 E. Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause, in each line. Interval Between Onset and Death Immediate Cause (Final Physician/ LOCALAC disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has performed Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Hospital: Certificate: To 1 Inpatient 2 YER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural injury 5 Pending Accident
Suicide
Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Dr. William Convey,

NOV

31. Date filed (Month, Day, Year)

32. Registrar's Signature

45 Thomas Johnson Dr., Suite 109, Frederick, MD 21702

Thomas Warren
10-08088 Briggs
Unk Unk

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ONK ONK		1- For State Registrar	Sta	ate of Maryla		-	ent of He ate of De		id Meni	tal Hygi		g. No.	2010	34994
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Funeral Director		5. Social Security N 212-66-6		6. Sex 7	7. Age (In)	yrs. last bin		Inder 1 Yea		1.00	Date of Pirt April 2			thplace (State or m Washington untry)
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Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Second 12 years	ondary (0-12)	College (1-4		<u> </u>	during most of ricklay	working life			one		ind of Business/I	•
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nore ages 1 gent of He nt: If it		1 XXBurial 2	Cremation	3 Removal from		cremat	ory or other pla rection C	ice)		11/6/20			,	
Baltimore, permit. Pages 1 ar Department of Hee Important. If ite	Ì	4 Donation 5 21. Signature of Fu	neratiService L	icensee		TROSULT	22. Name a	nd Address	s of Facility	George	e P. Ka	las l	inton, Mar Funeral H	
Physician	\dashv		e disease, or c	omplications that cau	ised the de	eath. Do no				d Oxon l	Hill, M	ary1	and 207	
/Medical Examiner		failure. List on Immediate Cause (or condition resultir		a. Ather			cardi	ovasc	ular	diseas	e			Between Onset and Death
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Division of Vital Records, P.O ral or Attending Physician: The law requires that its after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be deare	ompleted								,	[24a. Was ar autops perform Yes 2	y ned?		opsy findings available ompletion of cause of S
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E 8 E	Certification:	2 Accident 3 Suicide 4 Homicide	6 Could determ	not be 28e. Place o	of Injury - /	At home, fa	rm, street, facto	ory, office b	uilding, etc.		Location (Stoor Town, Sta		d Number or Rur	al Route Number, City
To the Hos within 24 h To the Fun completely	edical	one) 2 🗸	Medical Exam	sician: To the best of iner:On the basis of and manner stat	examinatio	vledge, dea on and/or ir	vestigation, in	my opinion	, death occi	e, and due turred at the t	o the cause time, date ar	(s) and o	manner as state e, and due to the	d. cause(s)
		29b. Signature and	111			\checkmark	My	9c. License O.C.I				_	ote signed (Mon	
		30. Name and addre Russell Alex		ho completed cause Assistant Me			111 Penr	Street,	Baltimor	e, MD 21	201			
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER 2010 4:43P PLATO NICHOLAS COUNDJERIS Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK Social Security Number 6. Sex 1 **X**M 2 □ F If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Country) 0270671926 071-18-8306 84 NY **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 🗌 Yes 2 🕱 No MD TALBOT OXFORD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? i and Mental Hygiene. 7 is marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be i Funeral 21654 UNITED STATES 27888 OTWELL ROAD Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner munor or other traumatic event, the Medical Examiner munor or other traumatic event. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. 1 X Yes 2 □ No If Yes, Give ð 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: WHITE Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 EXECUTIVE LADIES APPAREL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ NICHOLAS COUNDJERIS MELPOMENI NICHOGLAU 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7404 RIDGE ROAD, FREDERICK, MD 21702 JANE-MARIA KETCHEM, DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date 1 X Burial 2 Cremation 3 Removal from State ST. JOSEPH'S CEMETERY 10/21/2010 CORDOVA, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, PA 200 S. HARRISON ST., EASTON, MD 21601 MERCE ROM 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Respiratory failure Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. s been signed by the attending physician and should be detached for use as the burial-transit Spinal cord compression that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Septic shock Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4 Pregnant Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? liver failure, multiorgan dysfunction 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , page 2 autopsy 1 Yes 2 No Yes 2 X No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No iniury 1 🔀 Natural 5 Pending Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🔀 Ce 🥟 ing Phisician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. M. ical Exa iner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) rtifying Jurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and 29d. Date signed (Month. Day, Year)

State Registrar

725

ILTVA

400 W 7th St

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lev Agarunov

OCT 18 2010

31. Date filed (Month, Day, Year)

D0065378

Frederick, Md

10/12/2010

21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 0 Winifred Clarebell Crowl 8:45 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Tranquillity At Fredericktowne Frederick Frederick . Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number 6. Sex If Under If Under 24 Hrs 8. Date of Birth Funeral Days Hours Min 1 □ M 2X□ MT724/4932 Maryland Director 217-80-5763 Usual Residence of Decedent 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director or 28a-f sl notified 1X Yes 2 □ No Frederick Brunswick MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ems 23a or must be r Funeral USA 21716 510 9th. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Was Deces: Armed Forces? ¹ ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3X Widowed 4 □ Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. tant: If item 27 is marked other tha jury or other traumatic event, the I Housewife Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Ada Virginia Baker Everett Perry Hoffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 619 Brunswick Street, Brunswick MD. 21716 Betty Boyce, Sister permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 10/25/2010 4 Donation 5 Other (Specify) Park Heights Cemetery Brunswick, MD . Signature of Funeral Service Licensee 22. Name and Address of Facility John T Williams Funeral Home, Brunswick MD. 21716 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on a poll line. Approximate Interval Between Immediate Cause (Final Onset and Death Priysician, disease or condition Medical resulting in death) consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence oi). Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and use as the burial-trai Due to (or as a consequence of): attending physician for use as the hiria Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 4 ☐ Pregnant : g ☐ Unknown ped. Unknown signed by the be detact Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 1 Yes 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed page 2 1 ☐ Yes 2 ☐ No this certificate Division of Vital 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☐ No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred After 1 Natural iniury 5 Pending 24 hours after death. Funeral Director: A Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PLENING. BRUNSWICK MD 21716 ChRISTOPHER ER NINTH

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

arked

32. Regist ar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 0 2010 Medical Eacility Name (if not institution, give street and number County of Death Examiner 4b. City Town or Location of Death GEDRGES HEYERLY If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Days Hours Min E1 cosilvador 1 1 Day 969 216-31-0883 Director 40 Usual Residence of Decedent 28a-f shov and 2 should be filed within 72 hours after death with the Maryland Heath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show other tranmetic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 😿 Yes 2 🗌 No MD Prince George Hyattsville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 4213 71st Avenue 20784 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ 1 X Yes 2□No Specify: salvadoran Maryland 21215-0036 If Yes, Give Year or Dates Specify: Hispanic 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Meat Packer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Bernardo Avelar Maria Del Carmen Cruz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nery S. Alvarez 4213 71st Ave. Hyattsville, Maryland 20784 (Husband) other 1 Baltimore, 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place 10-22-10 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Silver Spring, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility W.H. Bacon Funeral Home, Inc. 3447 14th St. N.W. Washington, DC 20010 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enysician/ INTYACTANIAL HEMORR HAGE disease or condition DAM Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate וי attending physician and יביי יופפ as the burial-trar it Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ate has been signed by the atte page 2 should be detached for in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à EXTENSION Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy eral Director: After this certificate I filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: 1 Nnpatient 2 -ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work?
1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) within 24 hours a Medical 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year)

Registrar

State

31. Date filed (Month, Day, Year)

MCC

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GILBERT-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 34998 Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month October 2010 Yong Wook Cho 6:52a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1120 Fairland Road Silver Spring Montgomery If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗓 M 2 🗆 F Months Days Hours (Month, Day, Year) 01/06/1934 Country) Director Yrs Korea None Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🗓 No Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1120 Fairland Road 20904 Korea 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14, Race - American Indian. Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Specify Asian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mee life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Farmer Agriculture 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Sang Kyu Cho Soon Y Oh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Haeng Cho - Son 1120 Fairland Road. Silver Spring, Maryland 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Norbeck Memorial Park! 10/25/2010 | Olney, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home. 21. Signature of Funeral Service Licensee Wol 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Few Howrs Immediate Cause (Final Ph_sician/ Acute Cerebrovascular Accident disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last P Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death the a Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I ☐ Yes 2 🗶 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 X No Other: မ 1 Tes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 X Residence 6 Other (Specify) funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🗌 Yes completed filled in by the Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year)

State Registrar #410, Takoma Park, Maryland 20912

7610 Carroll Avenue.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

OCT 25 2010

Anees Ahsan.

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend #9,13 per FH, FCHD, LE Certificate of Death 10/26/10 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October Physician/ 2010 Maximino Crespo 12:42a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 109 Linden Avenue Frederick Frederick 8. Date of Birth (Month, Day, Year) 11,1940 If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign Country) Puerto Maryland Ric **Funeral** 7. Age (In yrs. last birthday) Min 1 ☑ M 2 ☐ F Yrs. Director 349-36-1056 70 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Frederick Maryland Frederick 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21703 United States 109 Linden Avenue death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2 X Married Completed by 1 X Yes If Yes, Give 72 hours after 2 No Baltimore, Maryland 21215-0036 1 ☑ Yes 2 ☐ No Specify: Puerto Rican 3 Widowed 4 Divorced Specify: Year or Dates. 1961-65 White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. World Health Org. 12 Loan Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ျှ Cruz Crespo Manuela Rivas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 shment of Health a Rose Crespo / Wife 109 Linden Avenue, Frederick, Maryland 21703 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of F
Important: If ite
any injury or ot 1 🖾 Burial 2 🗌 Cremation 3 🗌 Removal from State 22/2010 4 Donation 5 Other (Specify) Resthaven Memorial Gardens Frederick, Maryland. 21. Signature of Juneral Service Lic Stauffer Funeral 1621 Opossumtown Homes Pike, P. A. Frederick, Maryland 21702 s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, or complication shock, or heart failure. List only one ca Onset and Death Immediate Cause (Final MDS. Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Hepatic encephologu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami and -transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) ending physician use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) atten for u in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year the ed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? ۾| 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 Yes 2 No Yes or Attending Physician: 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 I No ပ ER/Outpatient 3 DOA 1 Inpatient 2 I After thi funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work ithin 24 hours after death.

the Funeral Director: Aft
ompleted filled in by the fur 1 Tes 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the I 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 10-19-2010 00067691 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 501 West 7th Street, Frederick, Maryland 21701 6+IVA Mark G. Goldstein 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT Registrar

DHMH 17 Rev 7/2009